Specifications:

Form – 145 – IMA Infosel Mailer Franked Form

Custom 3-part Continuous Pinfed Form, 9.5 x 17 perforated at 9.5 x 5 5/8, folded on perfs with encapsulated glue pressure strips For closure. Window on face 1¼ from bottom & 1½ from left side. Prints on 24# White Bond , Black ink 2 sided, packaged 1300 per Carton fanfolded.

Specifications:

Form – 1209 Recertification for Medical Assistance

Custom 6-part / 2-way mailer , Continuous Pinfed Form 12.6 x 6.0
With Hot Spot Carbon on parts 1,2,3,&4 with Blockouts. Parts 1 & 4
Same carbon pattern / part 5 & 6 Custom Ply-Saver Return Envelope
Parts 1 – 4 print on 16# White Bond , black ink 2 sides 5 & 6 on 24#
White Bond, black ink 2 sides. Carton Pack 800 to carton.
Inside Delivery Required

Part 1 File Cover Sheet
2 Face Outbound Carrier Env.
3 Application-front & back / English
4 Application-front & back / Spanish
5 Face Return Envelope
6 Backer Return Envelope

Specifications:

Form – , Food Stamp Reporting Form

Custom 6-part / 2-way mailer , Continuous Pinfed Form 12.6 x 6.0
With Hot Spot Carbon on parts 1,2,3,&4 with Blockouts. Parts 1 & 4
Same carbon pattern / part 5 & 6 Custom Ply-Saver Return Envelope
Parts 1 – 4 print on 16# White Bond , black ink 2 sides 5 & 6 on 24#
White Bond; black ink 2 sides. Carton Pack 800 to carton.
Inside Delivery Required

Part 1 File Cover Sheet
2 Face Outbound Carrier Env.
3 Application-front & back / English
4 Application-front & back / Spanish
5 Face Return Envelope
6 Backer Return Envelope

A

Income Maintenance Administration
Department of Human Services
Government of the District of Columbia

Your Food Stamps will end if you do not return this form!

Case No:

Report Month:

You must submit a report about your household to keep getting Food Stamps. We need the information asked for on this form to see if you are still eligible and to compute the amount of your monthly benefits. When you answer the questions, you must give information for everyone included in your food stamps. This includes parents or spouses who live with you but are not included in your Food Stamps because of their immigration status. This also includes information for sponsors of aliens, even if the sponsor does not live in your home. You can use a separate sheet of paper to explain any of your answers or give more information. Any separate sheet of paper must be sent in with this form. You must complete, sign and return this form to us by the 10th day of the report month listed above on this form. IF YOU NEED HELP TO COMPLETE THIS FORM, CALL YOUR WORKER.

HOT SPOT
(On The Reverse Side)

B

TO OPEN TEAR ALONG THIS PERFORATION
PEEL BACK TOP PLY TO REMOVE CONTENTS

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HUMAN SERVICES
INCOME MAINTENANCE ADMINISTRATION
DIVISION OF PROGRAM OPERATIONS
645 H STREET, N.E.
WASHINGTON, D.C. 20002

POSTMASTER: DO NOT FORWARD

Return Service Requested

Washington, D.C.
20001

Presorted
First Class
U.S. Postage
PAID
Permit No. 2754
Washington, D.C.

HOT SPOT
(On The Reverse Side)

IMPORTANT INFORMATION:
Please complete and return this form right away.

INFORMACION IMPORTANTE:
Favor de completer este formulario inmediatamente y devolverlo.

C

Income Maintenance Administration
Department of Human Services
Government of the District of Columbia

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Case No:

Report Month:

HOT SPOT
(On The Reverse Side)

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1. __YES __ NO DID ANYONE WORK OR RECEIVE INCOME FROM WORK DURING THE LAST 30 DAYS? ENTER THE AMOUNT OF PAY BEFORE TAXES (GROSS AMOUNT). **ATTACH PROOF.**

	Who	Pay Date	Amount	Pay Date	Amount	Pay Date	Amount	Pay Date	Amount
IF YES	1.								
	2.								

HOT SPOT
(On The Reverse Side)

2 . __ YES __ NO DID ANYONE GET ANY TYPE OF INCOME OTHER THAN WAGES OR PUBLIC ASSISTANCE? **ATTACH PROOF OF OTHER INCOME.**

	WHO	AMOUNT	DATE	HOW OFTEN RECEIVED	SOURCE
IF YES		$			
		$			

3. __ YES __ NO DID ANYONE HAVE ANY OTHER CHANGES OR EXPECT ANY CHANGES IN THE COMING MONTHS, SUCH AS JOB LOSS, PERSON(S) MOVED INTO OR LEFT HOME, CHANGE IN ADDRESS, OR CHANGE IN SHELTER COST.
ATTACH PROOF OF INCOME/RESIDENCE/EXPENSE CHANGES.

IF YES	WHAT	WHO	WHEN(DATE)
	EXPLAIN	AMOUNT	

D

5. __ YES __ NO DID ANYONE PAY CHILD SUPPORT TO SOMEONE WHO DOES NOT LIVE IN THE FOOD STAMP HOUSEHOLD? **ATTACH PROOF OF AMOUNT PAID.**

IF YES	WHO PAID	FOR WHOM	AMOUNT

4. __YES __ NO DID ANYONE PAY FOR CHILDCARE OR CARE FOR A SICK OR DISABLED PERSON? **ATTACH PROOF OF AMOUNT.**

IF YES	WHO PAID	FOR WHOM	AMOUNT

6. __ YES __ NO DID ANYONE HAVE CHANGES IN RESOURCES, LIKE BANK ACCOUNTS? **ATTACH PROOF.**

IF YES	WHAT	WHO

CERTIFICATION: I believe that all of my information on this form is correct. I have reported all of my changes on this form. I know that if I give any false information, I may be breaking the law.

I know that because of the changes in income I reported on this form:
1) that my Food Stamp and/or cash benefits may be reduced; or
2) that my Food Stamp and/or other benefits may be stopped.

DAYTIME PHONE NUMBER: _____

_____ Signature

_____ Authorized Representative

NOTICE

- If this form is late or incomplete, you may not get your food stamps on time.
- If you DO NOT return this form, we will close your Food Stamp case.
- If your case is closed, you may need to complete a new application.
- If you disagree with a decision to reduce or stop your benefit(s), you have the right to a fair hearing. You will be sent a notice about any reduction or stoppage of your benefits

PENALTIES FOR FRAUD: If you break the rules, then you could be fined and go to prison for up to 20 years. You may also lose your benefits for one year for the first violation, two years for the second violation, and permanently for the third violation.

YOUR RIGHT TO A HEARING

If you think that DHS has made a mistake, then you can get a Fair Hearing. At the Fair Hearing you can give the reasons for your appeal. You can ask someone else to speak for you. This can be an attorney, a friend, a relative, or someone else. You can also bring witnesses and present evidence. If you want free legal advice, call us for information. If you appeal within **10 days** from the due date, your cash and medical benefits will continue until a hearing decision is made, but your food stamp benefits will not continue unless you complete the interim reporting form. You may ask for a hearing by calling your worker, the Office of Administrative Review on 698-4650 or the Office of Administrative Hearings on 727-8280.

E

Administración de Mantenimiento de Ingreso
Departamento de Servicios Humanos
Gobierno del Distrito de Columbia

Sus cupones para alimentos terminarán si no devuelve este formulario

de caso:
Mes del informe:

Tiene que entregar un informe sobre su hogar para seguir recibiendo Cupones para alimentos. Necesitamos la información en este formulario para ver si todavía es elegible y para calcular el monto de sus beneficios mensuales. Cuando contesta las preguntas, tiene que proveer información para todas las personas incluidas en sus cupones para alimentos. Esto incluye padres o esposos que viven con usted pero no están incluidos en sus cupones para alimentos, debido a su estatus de inmigración. También incluye información de las personas que patrocinan extranjeros, inclusive si esta persona no vive en su casa. Puede usar otra hoja para explicar cualquiera de sus respuestas o dar más información. Cualquier hoja adicional debe ser enviada con este formulario. Tiene que llenar, firmar y devolver este formulario hasta el décimo (10mo) día del mes del informe que aparece anteriormente en este formulario. **SI NECESITA AYUDA PARA LLENAR ESTE FORMULARIO, LLAME A SU TRABAJADOR.**

1. __SÍ __ NO ¿ALGUIEN TRABAJÓ O RECIBIÓ INGRESO DE TRABAJO DURANTE LOS ÚLTIMOS 30 DÍAS? INGRESE EL MONTO DEL PAGO ANTES DE DEDUCIR IMPUESTOS (MONTO BRUTO). **ADJUNTE UN COMPROBANTE.**

	¿Quién?	Fecha	Monto	Fecha	Monto	Fecha	Monto	Fecha	Monto
SI RESPONDE SÍ	1.								
	2.								

HOT SPOT
(On The Reverse Side)

2 . __ SÍ __ NO ¿ALGUIEN RECIBIÓ ALGÚN TIPO DE INGRESO APARTE DE SALARIO O ASISTENCIA PÚBLICA? **ADJUNTE UN COMPROBANTE DE OTRO INGRESO.**

	¿Quién?	MONTO	FECHA	¿Con qué frecuencia recibe?	FUENTE
SI RESPONDE SÍ		$			
		$			

3. __ SÍ __ NO ¿ALGUIEN TUVO OTRO CAMBIO O ESPERA CAMBIOS EN LOS MESES VENIDEROS, COMO LA PÉRDIDA DE TRABAJO, PERSONAS QUE ENTRAN O SALEN DE LA CASA, CAMBIO DE DIRECCIÓN O CAMBIO EN EL COSTO DE LA VIVIENDA. **ADJUNTE UN COMPROBANTE DE LOS CAMBIOS DE INGRESO/RESIDENCIA/GASTOS.**

SI RESPONDE SÍ	¿QUÉ?	¿QUIÉN?	¿CUÁNDO? (FECHA)
	EXPLIQUE	MONTO	

F

5. __ SÍ __ NO ¿ALGUIEN PAGÓ MANUTENCIÓN INFANTIL PARA ALGUIEN QUE NO VIVE EN EL HOGAR QUE RECIBE CUPONES PARA ALIMENTOS? **ADJUNTE UN COMPROBANTE DEL MONTO PAGADO.**

SI RESPONDE SÍ	¿QUIÉN PAGÓ?	¿PARA QUIÉN?	MONTO

4. __SÍ __ NO ¿ALGUIEN PAGÓ POR CUIDADO INFANTIL O CUIDADO DE UNA PERSONA ENFERMA O DISCAPACITADA? **ADJUNTE UN COMPROBANTE DEL MONTO.**

SI RESPONDE SÍ	¿QUIÉN PAGÓ?	¿PARA QUIÉN?	MONTO

6. __ SÍ __ NO ¿ALGUIEN TUVO CAMBIOS EN RECURSOS, COMO CUENTAS BANCARIAS? **ADJUNTE UN COMPROBANTE.**

SI RESPONDE SÍ	¿QUÉ?	¿QUIEN?

CERTIFICACIÓN: Creo que toda la información en este formulario es correcta. He avisado de todos los cambios en este formulario. Sé que si doy información falsa puedo estar violando la ley. Sé que debido a los cambios indicados en este formulario:

1) que mis beneficios de Cupones para alimentos y/o de dinero en efectivo pueden ser reducidos; o
2) que mis beneficios de Cupones para alimentos y/u otros beneficios pueden ser terminados.

TELÉFONO DURANTE EL DÍA: _____

_____ Firma

_____ Representante autorizado

NOTIFICACIÓN

- Si este formulario no es entregado a tiempo o es incompleto, es posible que no reciba sus cupones para alimentos a tiempo.
- Si NO devuelve este formulario, cerraremos su caso de Cupones para alimentos.
- Si cerramos su caso, puede tener que llenar una solicitud nueva.
- Si no está de acuerdo con la decisión de reducir o para sus beneficios, tiene el derecho a una audiencia justa. Le enviaremos una notificación sobre cualquier reducción o terminación de sus beneficios

SANCIONES POR FRAUDE: Si viola las reglas, puede recibir una multa e ir a la cárcel por hasta 20 años. También puede perder sus beneficios por un año debido a la primera violación, por dos años debido a la segunda violación y permanentemente debido a la tercera violación.

SU DERECHO A UNA AUDIENCIA

Si cree que DHS ha cometido un error, puede obtener una Audiencia justa. En la Audiencia justa puede dar las razones por su apelación. Puede pedirle a alguien que hable por usted. Esta persona puede ser un abogado, un amigo, un pariente o alguien más. También puede llevar testigos y presentar pruebas. Si quiere consejos legales gratis, llámenos para obtener información. Si hace la apelación dentro de los **10 días** de la fecha de entrega, sus beneficios de dinero en efectivo y beneficios médicos seguirán hasta tener una decisión de audiencia, pero sus beneficios de cupones para alimentos no seguirán a menos que complete el informe del periodo transitorio. Puede pedir una audiencia al llamar a su trabajador, la Oficina de Revisión Administrativa al 698-4650 ó la Oficina de Audiencias Administrativas al 727-8280.

G

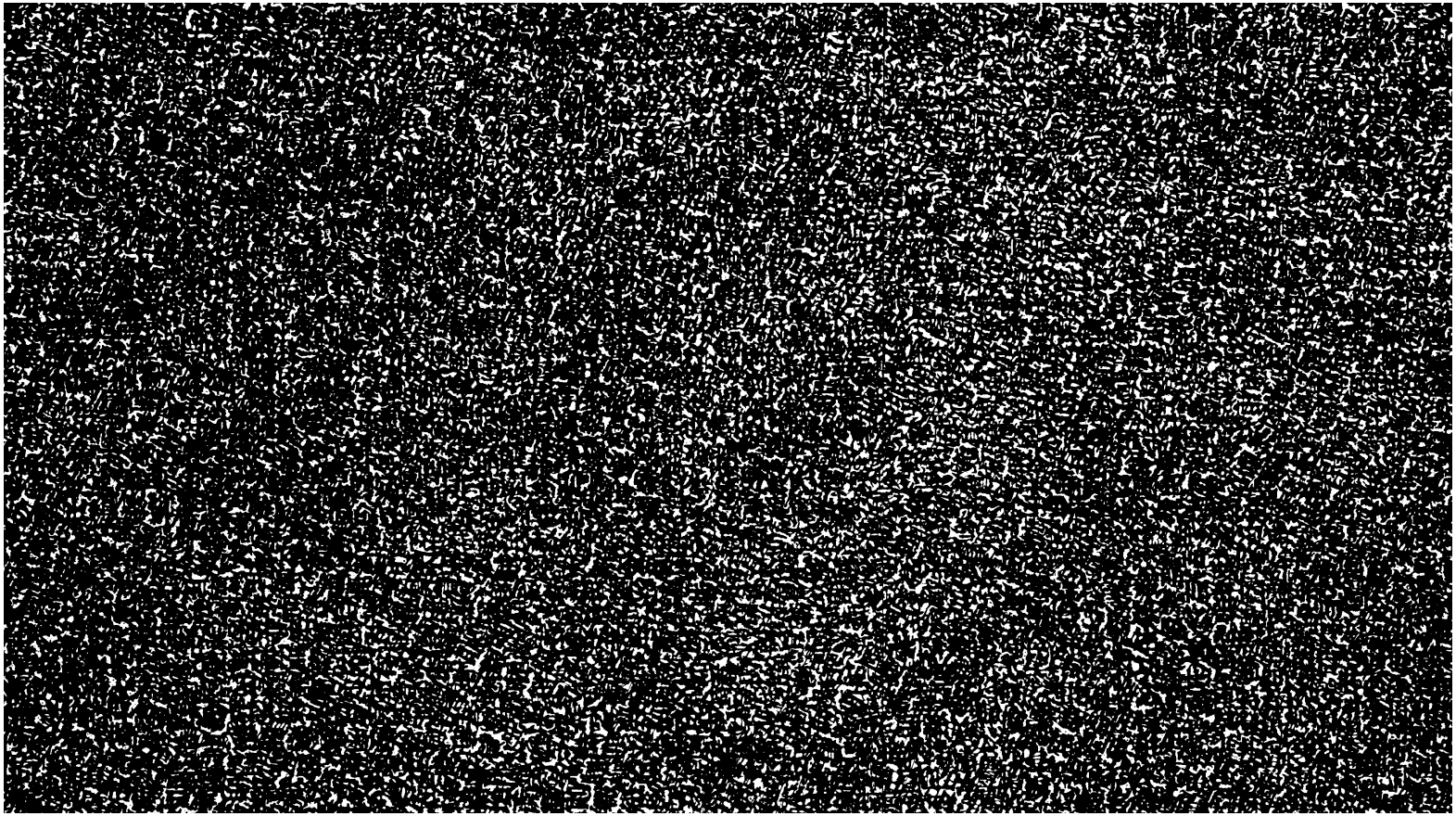
F _____

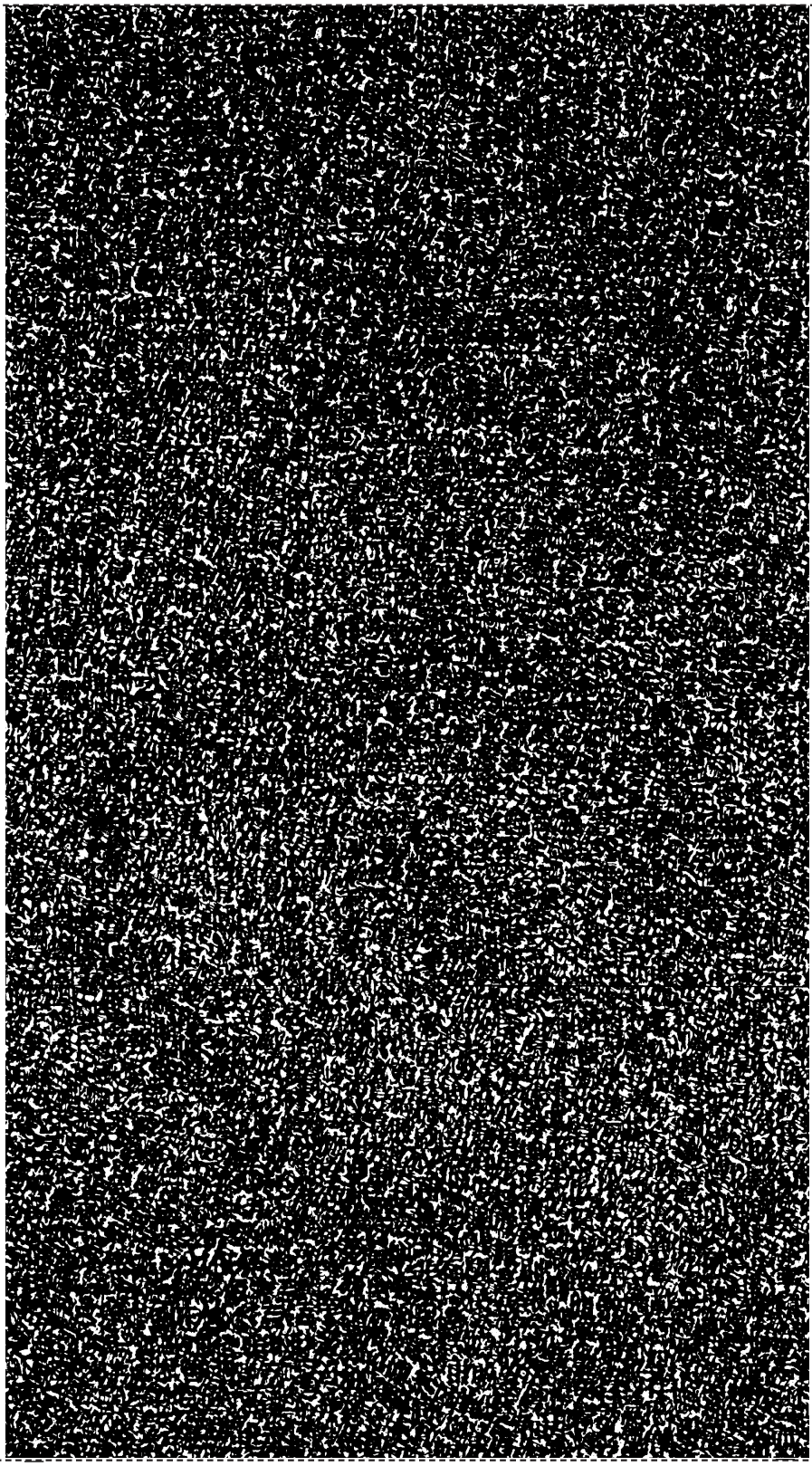
R _____

O

M _____

PLACE
STAMP
HERE





PENALTY WARNINGS

FOOD STAMPS

Any member of your household who breaks any of the following rules on purpose will not be able to get food stamps for 1 year after the first violation and 2 years after the second time. The third time a member breaks the rules, he/she will never get food stamps again. Any member who uses food stamps to get a controlled substance will not be able to get food stamps for 2 years after the first time and permanently after the second time. Any member of the household who is convicted of trafficking food stamp benefits in the amount of $500 or more will never get food stamps again. Any member of the household who is found to have made a fraudulent statement or representation about identity or residence in order to get multiple benefits at the same time will not be able to get food stamps for 10 years. Any member who uses food stamps to get guns, ammunition or explosives will never get food stamps again. This individual can also be fined up to $250,000, sent to jail for up to 20 years, or both. Under other federal laws, additional criminal or civil action may be taken against the individual.

DO NOT give false information or hide information to get or continue to get food stamps.
DO NOT trade or sell food stamps or authorization cards.
DO NOT alter authorization cards to get food stamps you're not entitled to receive.
DO NOT use food stamps to buy ineligible items, such as alcoholic drinks and tobacco.
DO NOT use someone else's food stamps or authorization cards for your household.

TANF FRAUD

You must report all changes in your income and resources by the 10th day of the month after the change happens. If a child is leaving your home for over 90 days you must report that within 5 days after the child leaves. You may be subject to prosecution for fraud if you knowingly give false, incorrect or incomplete information in order to receive or try to receive, or help someone else receive, TANF assistance. You will be required to repay all or part of the TANF assistance received improperly for any person.

MEDICAL ASSISTANCE FRAUD

You may be subject to prosecution for fraud if you knowingly give false, incorrect or incomplete information in order to receive or try to receive or help someone else receive, Medical Assistance. If you are found guilty of committing fraud, you could be fined up to $1,000, sentenced to a prison term up to one year or both. In the event of misuse or abuse, your eligibility for Medical Assistance may be restricted for a minimum of one year.

MEDICAID PROCESSING

You are responsible for submitting all of the documents and providing all of the information requested in connection with your Medicaid application. If you return all of the documents requested, the Department of Human Services MUST either approve or disapprove your request within 45 days of the date you submitted your Medicaid application, unless you specifically request a delay in making an eligibility determination and the Department of Human Services agrees to such delay. You can request a delay in writing, in person or by telephoning your social service worker. If you have not received notice that your application was either approved or disapproved within 45 days please call your social service worker and/or his or her supervisor. If you believe that the processing of the Medicaid application has been improperly delayed beyond 45 days, you can obtain free legal assistance by calling the firm of Terris, Pravlik & Millian, 1121 12th Street, NW., Washington, D.C. 20005, (202) 682-0578.

You are responsible for submitting all of the documents and providing all of the information requested in connection with recertification of your Medicaid eligibility. If you return all of the documents requested before the end of your current Medicaid eligibility period, the Department of Human Services MUST either approve or disapprove your request or continue your eligibility until a determination of ineligibility is made and you are given written notice of that decision. If you are determined no longer to be eligible for Medicaid, you have a right to request a hearing to challenge that determination. If you have not received written notice that your recertification has either been approved or denied by the end of your current eligibility period, and your eligibility has not been continued, you can obtain free legal assistance by calling the firm of Terris, Pravlik & Millian, 1121 12th Street, NW., Washington, D.C. 20005, (202) 682-0578.

REFUND FOR OUT OF POCKET EXPENSES

If you have incurred out-of-pocket expenses for medical services or prescriptions after you applied for Medical Assistance (or the D.C. Healthy Families program) or in the three months prior to your application, you may be eligible for reimbursement from the District. You must make a claim within six months of when you make the out-of-pocket payment or within six months of when you are notified that you are eligible for Medicaid, whichever is later. You may obtain free legal assistance and help in making a claim from Terris, Pravlik & Millian at (202) 682-0578 or you may call the Recipient Claims Research Team at (202) 698-2009.

ELIGIBILITY VERIFICATION SYSTEM (EVS)

If, during a period when you are eligible for Medical Assistance, the eligibility verification system (EVS) informs you or your provider that you are not eligible for Medical Assistance and you dispute that determination, you may obtain free legal assistance by contacting Terris, Pravlik & Millian, 1121 12th Street, NW., Washington, D.C. 20005, (202) 682-0578. Your provider has been instructed to call the EVS backup system.

INCOME MAINTENANCE ADMINISTRATION
645 H ST., N.E.
WASHINGTON DC 20002

PRESORTED
FIRST-CLASS MAIL
U.S. POSTAGE PAID
WASHINGTON, D.C.
PERMIT NO. 2754

PENALTY WARNINGS

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INCOME MAINTENANCE ADMINISTRATION
645 H ST., N.E.
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WASHINGTON, D.C.
PERMIT NO. 2754

K

Income Maintenance Administration
Department of Human Services
Government of the District of Columbia

Your Health Insurance Will Soon End!

Case No.:

Eligibility End Date:

It is time to recertify for Medical Assistance. If you do not return this form, **you will lose your free health insurance**. Please complete this form and mail it or take it to the address listed on the enclosed envelope. We will mail you a notice when we get your signed form. If you answered "YES" to any questions on the back, you must send us copies of the documents listed there. If you return all of the documents before your Medical Assistance eligibility ends, then you will keep your Medical Assistance until we redetermine your eligibility. We will send you a notice of our decision. If you disagree with our decision, you can request a fair hearing. Also, if Medicaid or EVS makes a mistake and tells your medical provider that you are not eligible, you can get help with this. To get free legal help with these issues, call Terris, Pravlik and Millian on 202-682-0578 or write to them at 1121 12th Street, NW, Washington, DC 20005. **If you are a US citizen you need to provide a picture ID and proof that you are a US citizen. This proof can be a passport OR a birth certificate and a picture ID. Only original documents can be accepted. You may mail these documents to us and we will return them to you by mail or you may bring them to the address on the enclosed return envelope. These documents are required for every US citizen listed below. You do not have to provide this proof for anyone who receives SSI, Healthcare Alliance or Medicare. It is also not needed for anyone who is not a US citizen. If you do not have these documents, we may be able to help you get them or other documents that we can accept.**

HOT SPOT
(On The Reverse Side)

Cross out anyone who has moved. Add new members of your household.

Last Name	First Name	MI	Date of Birth	Sex

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.

WIC is a program for children under 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.

TO OPEN TEAR ALONG THIS PERFORATION
PEEL BACK TOP PLY TO REMOVE CONTENTS

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HUMAN SERVICES
INCOME MAINTENANCE ADMINISTRATION
DIVISION OF PROGRAM OPERATIONS
645 H STREET, N.E.
WASHINGTON, D.C. 20002

POSTMASTER: DO NOT FORWARD

Return Service Requested

WASHINGTON, D.C. 20001

Presorted
First Class
U.S. Postage
PAID
Permit No. 8176
Washington, D.C.

It is time to recertify for Medical Assistance. If you do not return this form, **you will lose your free health insurance**. Please complete this form and mail it or take it to the address listed on the enclosed envelope. We will mail you a notice when we get your signed form. If you answered "YES" to any questions on the back, you must send us copies of the documents listed there. If you return all of the documents before your Medical Assistance eligibility ends, then you will keep your Medical Assistance until we redetermine your eligibility. We will send you a notice of our decision. If you disagree with our decision, you can request a fair hearing. Also, if Medicaid or EVS makes a mistake and tells your medical provider that you are not eligible, you can get help with this. To get free legal help with these issues, call Terris, Pravlik and Millian on 202-682-0578 or write to them at 1121 12th Street, NW, Washington, DC 20005. **If you are a US citizen you need to provide a picture ID and proof that you are a US citizen. This proof can be a passport OR a birth certificate and a picture ID. Only original documents can be accepted. You may mail these documents to us and we will return them to you by mail or you may bring them to the address on the enclosed return envelope. These documents are required for every US citizen listed below. You do not have to provide this proof for anyone who receives SSI, Healthcare Alliance or Medicare. It is also not needed for anyone who is not a US citizen. If you do not have [illegible] we will help you get them or other documents that we can accept.**

HOT SPOT
(On The Reverse Side)

DC Healthy Families

Because some of the best things in life are free.

It is time to renew your health insurance. Please complete and return this form right away.

Es hora de renovar su seguro de salud. Favor de completar este formulario inmediatamente.

M

Income Maintenance Administration
Department of Human Services
Government of the District of Columbia

Your Health Insurance Will Soon End!

Case No.: HOT SPOT (On The Reverse Side)

Eligibility End Date:

It is time to recertify for Medical Assistance. If you do not return this form, **you will lose your free health insurance**. Please complete this form and mail it or take it to the address listed on the enclosed envelope. We will mail you a notice when we get your signed form. If you answered "YES" to any questions on the back, you must send us copies of the documents listed there. If you return all of the documents before your Medical Assistance eligibility ends, then you will keep your Medical Assistance until we redetermine your eligibility. We will send you a notice of our decision. If you disagree with our decision, you can request a fair hearing. Also, if Medicaid or EVS makes a mistake and tells your medical provider that you are not eligible, you can get help with this. To get free legal help with these issues, call Terris, Pravlik and Millian on 202-682-0578 or write to them at 1121 12th Street, NW, Washington, DC 20005. **If you are a US citizen you need to provide a picture ID and proof that you are a US citizen. This proof can be a passport OR a birth certificate and a picture ID. Only original documents can be accepted. You may mail these documents to us and we will return them to you by mail or you may bring them to the address on the enclosed return envelope. These documents are required for every US citizen listed below. You do not have to provide this proof for anyone who receives SSI, Healthcare Alliance or Medicare. It is also not needed for anyone who is not a US citizen. If you do not have these documents, we may be able to help you get them or other documents that we can accept.**

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Cross out anyone who has moved. Add new members of your household.

Last Name	First Name	MI	Date of Birth	Sex

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.

WIC is a program for children under 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.

Answer These Questions

1. Have you moved since last year? ❑ YES ❑ NO
   If YES, write your new address here:

2. Have you attached your proof of income? ❑ YES ❑ NO
   You **must** provide proof of income (e.g., your most recent paystubs). If you have no income, please check this box. ☐

3. Do you pay for childcare or eldercare? ❑ YES ❑ NO
   If YES, you **must** attach receipts to get this deduction.

4. Has your immigration status changed? ❑ YES ❑ NO
   If YES, tell us whose status changed.

5. Does anyone have Medicare or 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.

6. **Seniors/disabled, Alliance and 50-64 customers:**
   Do you have $1,000 or more in liquid assets? ❑ YES ❑ NO
   If YES, attach proof of assets (e.g., bank statement).

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 any false information, I may be breaking the law.

X _____ _____
Signature Date

Your Telephone _____

Administración de Mantenimiento de Ingreso
Departamento de Servicios Humanos
Gobierno del Distrito de Columbia

¡Su Seguro de salud Terminará Pronto!

Número de caso:

Fecha Final de Eligibilidad:

Es hora de recertificar para su Asistencia Médica. Si no devuelve este formulario, **perderá su seguro de salud gratis**. Por favor complete este formulario y envíelo o llévalo a la dirección indicada en el sobre adjunto. Le enviaremos un aviso cuando recibamos su formulario firmado. Si contestó "Sí" a alguna pregunta al lado reverso, tiene que enviarnos copias de los documentos indicados allí. Si devuelve todos los documentos antes de que termine su elegibilidad para Asistencia Médica, mantendrá su Asistencia Médica hasta que redeterminemos su elegibilidad. Le enviaremos un aviso de nuestra decisión. Si no está de acuerdo con nuestra decisión, puede pedir una audiencia justa. Además, si Medicaid o EVS comete un error y avisa a su proveedor médico que usted ya no es elegible, puede obtener ayuda. Los clientes de Medicaid pueden obtener ayuda legal gratis de Terris, Pravlik and Millian a llamar al 202-682-0578 o escribir a 1121 12th Street, NW, Washington, DC 20005. Para obtener ayuda legal con asuntos de la Healthcare Alliance (Alianza de Cuidado de Salud), llame al Centro de Cambios de IMA al 202-727-5355 para una lista de servicios legales gratis. Si usted es un/a ciudadano/a de los Estados Unidos tiene que proporcionar una tarjeta de identificación con foto y una prueba de su ciudadano/a. Esta prueba puede ser un pasaporte o un certificado de nacimiento y una tarjeta de identificación con foto. Solo podemos aceptar documentos originales. Puede enviar estos documentos por correo y los devolveremos por correo o puede llevarlos a la dirección en el sobre adjunto. Es necesario tener estos documentos para cada ciudadano/a de los Estados Unidos indicado a continuación. No tiene que proporcionar esta prueba para personas que reciben Ingreso de Seguro Suplemental (SSI, por sus siglas en inglés), Seguro de Discapacidad de Seguro Social, Cuidado de Crianza, Asistencia para Adopciones, Healthcare Alliance o Medicare. Tampoco es necesario entregar esta prueba para personas que no son ciudadanos/as de los Estados Unidos. Si no tiene estos documentos, podemos ayudarle a obtener los documentos u otros documentos que aceptamos.

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Tache cualquier persona que ya no vive en las casa. Añada los nuevos miembros de su casa:

Apellidos	Nombres	I	Cuando nacio	Sexo

Referencias

HealthCheck provee chequeos gratis para niños que reciben Medicaid. También paga por otros servicios que un niño necesita. HealthCheck también le puede proveer viajes gratis al médico. Para obtener, llame al 1-888-557-1116.

WIC es un programa para niños menor de 5 años de edad. Con WIC, usted puede ahorrar hasta $140 cada mes en comida. Para obtener más información, llame al (202) 645-5663.

Si usted es elegible para recibir Asistencia Médica, puede recibir dinero de vuelta por cuentas médicas recientes que ha pagado. Medicaid también puede cubrir algunas cuentas que todavía están sin pagar. Para obtener más información, llame al (202) 698-2009.

Conteste Estas Preguntas

1. ¿Se ha cambiado de casa desde en año pasado? ❑ SÍ ❑ NO
   Si responde SÍ, escriba su nueva dirección aqui.

   _____

2. ¿Ha incluido ajunto prueba de su ingreso? **Tiene que** proveer pruebas de su ingreso (por ejemplo, sus recibos de pago más recientes). ❑ SÍ ❑ NO
   Si no tiene ningún ingreso, marque esta casilla. ☐
3. ¿Pago por cuidado infantil o por cuidado de alguien de la tercera edad el año pasado? Si responde SÍ, tiene que adjuntar recibos para recibir esta deducción. ❑ SÍ ❑ NO
4. ¿Ha cambiado su estatus de inmigrante? ❑ SÍ ❑ NO
   Si ha cambiado, indíquenos quién ha tenido el cambio.

   _____

5. ¿Alguien tiene Medicare o seguro? Si responde SÍ, incluya adjunto copias de sus tarjetas de Medicare o seguro privado. **Nota:** todavía puede recibir Medicaid de DC si tiene otro seguro. ❑ SÍ ❑ NO
6. **Para clientes de tercera edad/personas discapacitadas, Alliance y los de 50-64 años:** ¿Tiene $1,000 o más en bienes líquidos? Si responde SÍ, incluya adjunto pruebas de bienes (por ejemplo, estado de cuenta del banco). ❑ SÍ ❑ NO

Firme Aquí

Creo que toda la información en este formulario de dos páginas es correcta. He informado de todos mis cambios en este formulario. Sé que si doy información falsa, puedo estar violando la ley.

X _____ _____
Firma Fecha

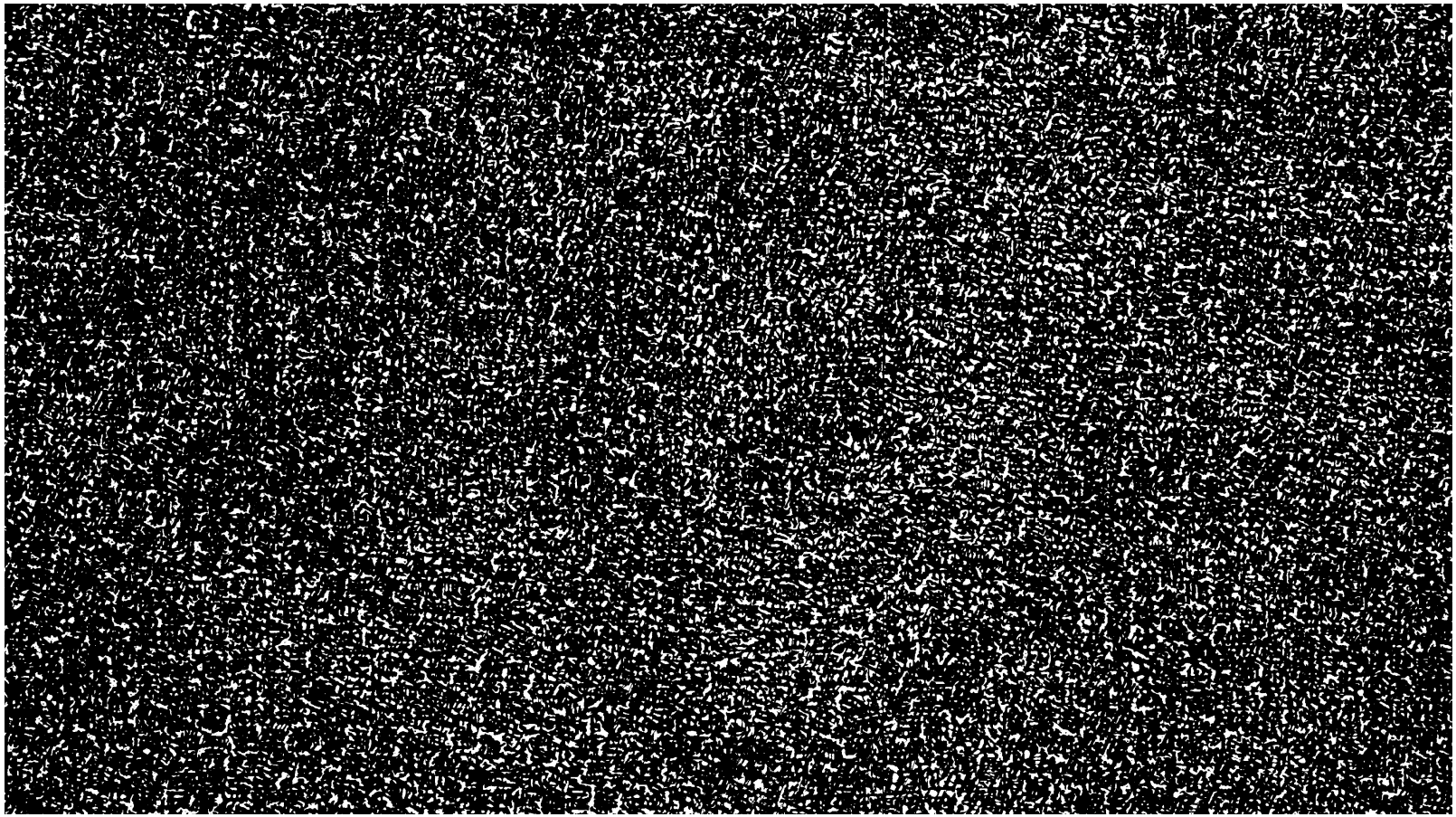
Su teléfono: _____

G

F _____

R _____

O

M _____

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