COMBINED APPLICATION FOR DC*

FOOD STAMPS (SNAP BENEFITS)
CASH ASSISTANCE (TANF for FAMILIES with CHILDREN or INTERIM DISABILITY ASSISTANCE for the DISABLED)
MEDICAID (for the ELDERLY or DISABLED)
HEALTHCARE ALLIANCE/ IMMIGRANT CHILD PROGRAM

*APPLICANTS FOR MEDICAID FOR FAMILIES WITH CHILDREN (INCLUDING TANF APPLICANTS) OR A NON-DISABLED/NON-ELDERLY ADULT MUST FILE A DC HEALTH LINK APPLICATION (See Next Page)

If you live in DC, you can use this form to apply for benefits. If you need help with this form, just ask your worker or another ESA employee. You can also call (202) 727-5355. Free interpreters are available.

Please bring this to your Service Center. To find out which Center is closest to you, call (202) 727-5355. You may also mail this form to DHS/CRMU, 645 H St., NE, Washington, DC 20002.

☐ 是，我說中文 (MANDARIN)

“如果您住在D.C.，您可以使用这份表格申请福利。如果您填写这份表格时需要帮助，您可以向工作人员或其他IMA员工询问。您还可以致电 (202) 727-5355 我们有免费翻译服务。”

“請將該表格送到您所在地區的服務中心。欲知離您處所最近的服務中心的地址，請致電 (202) 727-5355，您也可以將此表格寄至 645 H St., NE Washington, DC 20002.”

☐ Sí, hablo ESPAÑOL (SPANISH)

Si usted vive en DC, puede usar este formulario para solicitar beneficios. Si necesita ayuda con este formulario, pídale ayuda a su trabajador u otro empleado de ESA. También puede llamar al (202) 727-5355. Intérpretes gratis están disponibles.

Por favor, lleve este formulario al Centro de Servicio de su área. Para saber cuál Centro le queda más cerca, llame al (202) 727-5355. También puede enviar este formulario por correo a 645 H St., NE, Washington, DC 20002.

Questions? ¿Preguntas? 的问题？有問題嗎？Có thác mắc gì không?

📞 (202) 727-5355

☐  for AGENCY USE ONLY

Case Name _________________________Case # _______________________
Date Rec’d ________________________Prog. Approved ______________________
Date Disp. _________________________Prog. Denied _______________________

ESA Combined Application: December 2015
ECONOMIC SECURITY ADMINISTRATION
SERVICE CENTERS

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 Ave., 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

Customers may call ESA at (202) 727-5355
to learn which Service Center serves their address.

IMPORTANT NOTICE ABOUT APPLYING for MEDICAID

Unless you are 65 years or older or you are disabled you need to complete a DC Health Link Application for Health Coverage to get Medicaid. If you are applying in person at one of the offices listed above you can ask for a paper copy of the Health Link Application. If you want to file an on-line application for Medicaid go to the DC Health Link Website at DCHealthLink.com. You can also call the DC HealthLink Customer Service Center toll-free at 1-855-532-5465 for help applying.

Questions? ¿Preguntas? 有問題嗎？Có thử mắc gì không?

📞 (202) 724-5506.
Your Information

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Middle Name</th>
<th>Date of Birth</th>
<th>Telephone</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Current Address</th>
<th>Apt.</th>
<th>Mailing Address (if different)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>City, State</th>
<th>ZIP</th>
<th>Are you Homeless?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Do you plan to stay in DC?</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

I am applying for:  
- [ ] Medical Assistance/QMB  
- [ ] Food Stamps  
- [ ] IDA (Interim Disability Assistance)  
- [ ] TANF/GC (Temporary Assistance for Needy Families/General Assistance for Children)

**Note:** Your Food Stamp benefits start on the day that you apply. You can apply right away. Make sure to write down your name and address above and then sign at the bottom of this page.

**Expedited Food Stamps**

You might be able to get Food Stamps in less than a week! To see if you qualify, please tell us:

1. Will your household income be more than $150 this month?  
   - [ ] Yes  
   - [ ] No

2. Do you have more than $100 in cash or in the bank?  
   - [ ] Yes  
   - [ ] No

3. Is your income & ready cash this month more than your rent and utilities?  
   - [ ] Yes  
   - [ ] No

If you answered NO to the questions above, then you may be eligible. Please tell us:

(a) What will be your total income this month? $__________; (b) How much do you have in cash or the bank? $__________; and (c) What did you pay for housing (rent/ utilities) this month? $__________

4. Are you or anyone in your household a migrant or seasonal farm worker?  
   - [ ] Yes  
   - [ ] No

**Authorized Representative**

Do you want someone else to act for or represent you?  
- [ ] Yes  
- [ ] No

If YES, please tell us:

- Name of Your Authorized Representative: __________________________
- Address of Rep.: _________________________________________
- Telephone of Rep.: _____________________________

What do you want them to do?  
- [ ] Do interviews  
- [ ] Make Inquiries  
- [ ] Report changes  
- [ ] Use EBT card

**Signature**

By signing below, I give my permission to DHS to get information about me. DHS can get this from my employer, landlord, bank, and utility company. I give all of these people my permission to give information about me to DHS. I have reviewed the information in my application and I believe that all of my information on this entire eight-page form is true and correct. I know that if I give any 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 with their investigations.

I agree to follow the rules for DHS benefits. I have received a copy of these rules. I know that I will have to recertify for my benefits. I also understand that my child may get free health care through "HealthCheck."

**Authorized Representatives:** If the applicant cannot sign this form, you may sign it for them. By signing, you certify that this person wants to apply for benefits and agrees to the conditions above.

**SIGNATURE:** X ______________________  **DATE:** ________________________

December 2015
<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Middle Name</th>
<th>Applying for this Person? (Yes/No)</th>
<th>Sex (M/F)</th>
<th>Date of Birth</th>
<th>Age</th>
<th>Social Security Number*</th>
<th>Relation to you (child, aunt, friend, etc.)</th>
<th>Do you eat together? (Yes/No)</th>
<th>U.S. Citizen? (Yes/No)**</th>
</tr>
</thead>
<tbody>
<tr>
<td>(You)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>(Self)</td>
<td>(n/a)</td>
<td></td>
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<td>2.</td>
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<td>3.</td>
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<td>4.</td>
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<td>5.</td>
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<tr>
<td>6.***</td>
<td></td>
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</tr>
</tbody>
</table>

* You can leave this blank if this person does not have an SSN or does not want benefits. However, you may still have to report this person’s income and assets.

** Many immigrants are eligible for benefits. To see if you may qualify, please fill out all of page 6.

*** Attach another sheet if more than six people live in your house.

### General Questions

1. Are you: □ Single □ Married □ Divorced □ Separated □ Widowed (Not needed for Food Stamps)
2. Is anyone in the military or a U.S. Veteran? □ Yes □ No
   If YES, who?
3. Is anyone pregnant? □ Yes □ No (Not needed for Food Stamps)
   If YES, who?
   When is the baby due?
4. Are you in a long-term care facility (nursing home, ICF-MR, CRF, etc.)?
   □ Yes □ No
   If YES, where?
5. How much do you pay for child-care or elder-care (day care, babysitter, etc.)? $ How often do you pay this?
6. Are you or anyone in your household hiding or running from the law to avoid prosecution, being taken into custody, going to jail for a felony crime or attempted felony, or violating a condition of parole or probation? □ Yes □ No
   If YES, who?
7. Have you gotten benefits from another State in the last three (3) months? □ Yes □ No
   If YES, where?
8. Does anyone age 16 or older go to school or a job-training program?
   Name of the school or program?
   □ Yes □ No
   If YES, who?
   How many hours per week?
9. In the last two (2) months, did anyone stop working or cut back on their hours? □ Yes □ No
   Reason? ___________________ What was their last day at work? ___________________ Date of final paycheck: ___________________

December 2015
### Income

**Income from Work** *(before* taxes or other deductions: gross, not net amount)*

Are you or is anyone in your house working?    ☐ Yes    ☐ No

<table>
<thead>
<tr>
<th>Person who is working</th>
<th>Employer’s Name/Telephone</th>
<th>Start Date</th>
<th>How much is each paycheck? <em>(before</em> taxes)</th>
<th>How often do you get paid? <em>(weekly, biweekly, monthly, etc.)</em></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>$ (GROSS)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>$ (GROSS)</td>
<td></td>
</tr>
</tbody>
</table>

### Other Income

Do you or anyone else get any other income? Please check all that apply and list each payment below.

- ☐ SSI
- ☐ Social Security (not SSI)
- ☐ Unemployment/Workers Comp.
- ☐ Pensions and retirement
- ☐ Child support
- ☐ Help with expenses
- ☐ Foster care/adoption subsidy
- ☐ Veterans benefits
- ☐ Other ______________

<table>
<thead>
<tr>
<th>Type of Payment</th>
<th>Who gets this?</th>
<th>How much is each payment? <em>(before</em> taxes and deductions)</th>
<th>How often do they get this? <em>(weekly, biweekly, monthly, etc.)</em></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>$ (GROSS)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>$ (GROSS)</td>
<td></td>
</tr>
</tbody>
</table>

Does anyone pay your family for meals or to rent a room (for example, a *roommate* or *boarder*)?

- ☐ Yes    ☐ No    If YES, who pays? ____________ How much do they pay each month? $ ____________

### Assets

<table>
<thead>
<tr>
<th>Cash</th>
<th>Does anyone have more than $1,000 in cash? If YES, how much $ ____________</th>
<th>☐ Yes    ☐ No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bank Accounts</td>
<td>Does anyone have more than $1,000 in the bank? If YES, please attach your most recent bank statement(s).</td>
<td>☐ Yes    ☐ No</td>
</tr>
<tr>
<td>Life Insurance</td>
<td>Does anyone have life insurance that they can cash in? If YES, how much money would you get if you cashed it in today? $ ____________</td>
<td>☐ Yes    ☐ No</td>
</tr>
<tr>
<td>Real Property</td>
<td>Does anyone own property besides the home you live in? <em>(For example: boats, rental property, real estate)</em></td>
<td>☐ Yes* ☐ No</td>
</tr>
<tr>
<td>Car</td>
<td>Does anyone own a car, truck or van? If YES, list Make, Model and Year below. Is it used by someone who’s sick/disabled?</td>
<td>☐ Yes ☐ No</td>
</tr>
<tr>
<td>Other</td>
<td>Does anyone have any stock, bonds, etc.?</td>
<td>☐ Yes* ☐ No</td>
</tr>
<tr>
<td>Transfers</td>
<td>Did anyone sell, trade, or give away anything worth more than $1,000 during the last three (3) years?</td>
<td>☐ Yes* ☐ No</td>
</tr>
</tbody>
</table>

* If YES, please attach a description to this form.

December 2015
For the Blind and Disabled
(Medical Assistance and IDA Only)

Is anyone in your house **blind** or severely **disabled**?  □ Yes  □ No  If YES, who? ______________

To get DC Disability Medicaid and Interim Disability Assistance (IDA), you may need to show that you are blind or disabled. Please get a Medical Form and have a doctor fill it out. If you do not have a doctor, call the DC Department of Healthcare Finance’s Office of the Ombudsman on (202) 724-7491. They can help you find a doctor. The doctor will fill out the Medical Form for you. DHS will treat all of your information as confidential.

**Note:** You do **not** need to fill out a Medical Form (856) if you are **age 65 or older** or if a **child under 19 lives with you**. Also, you may not need to fill out the form if you get Social Security disability benefits. If you have questions, please ask your worker or call (202) 727-5355.

### Housing, Utilities, & Other Bills
(Food Stamps Only)

Your Food Stamps amount may depend on your housing, utility, and medical bills. Please tell us the current amount of these bills. Do **not** include any past due amount. To qualify for more Food Stamps, you must provide proof of these bills. If you do not, we will assume that you do not want this deduction.

#### Rent or Mortgage

<table>
<thead>
<tr>
<th></th>
<th>Rent</th>
<th>Mortgage</th>
<th>Monthly Property Taxes*</th>
<th>Homeowners Insurance*</th>
<th>Condo Fee*</th>
<th>Other (describe below)</th>
</tr>
</thead>
<tbody>
<tr>
<td>How much?</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>Who pays?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Do not list property tax, insurance, or condo fees separately, if they are already included in your rent/mortgage amount.

Do you pay for heating or air-conditioning separately from your rent?  □ Yes  □ No

Did you get LIHEAP (Low Income Home Energy Assistance Program) benefits during the past 12 months?  □ Yes  □ No  If yes, how much did you get?  $_____________

#### Utility Bills (if separate from rent/mortgage)

Do you pay any money for the following utilities (separate from your rent)?
- Electric Bill
- Gas Bill
- Fuel Oil
- Water Bill
- Phone Bill (including cell)
- Other _________________________

#### Other Bills

1. Is there anyone who is disabled or age 60 or older who pays medical bills?
   □ Yes  □ No  If YES, who pays? ______________  How much do they pay each month?  $_____________

2. Does anyone in your home **pay** child support?
   □ Yes  □ No  If YES, who pays? ______________  How much do they pay each month?  $_____________

December 2015
We can help you get child support for the children for whom you are applying. Please tell us about any absent parents (any parents not living with their child). However, you could have a good reason for not telling us about an absent parent. If you are afraid that an absent parent might hurt you or someone in your family, then you have a good reason. If you have a good reason, then you do not have to give any information now.

Do you have a good reason for not telling us about an absent parent?  

☐ Yes  ☐ No

If NO, then you need to fill in the information below.

<table>
<thead>
<tr>
<th>Child with Absent Parent: Child # 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child’s Name</td>
</tr>
<tr>
<td>City:</td>
</tr>
<tr>
<td>Was this child born at full term? Yes ☐ No ☐</td>
</tr>
<tr>
<td>If no, at how many weeks was this child born?</td>
</tr>
</tbody>
</table>

I certify that Child #1 listed above was conceived as a result of sexual intercourse with the alleged parent I have listed at the location I listed above.

Signature:

<table>
<thead>
<tr>
<th>Paternity Established?</th>
<th>Voluntary Support</th>
<th>Court-Ordered Child Support</th>
</tr>
</thead>
<tbody>
<tr>
<td>Has paternity been established? Yes ☐ No ☐</td>
<td>Date you last received money from the Absent Parent</td>
<td>Court</td>
</tr>
<tr>
<td>If so, by what means?</td>
<td></td>
<td>Date ordered</td>
</tr>
<tr>
<td></td>
<td></td>
<td>City, State</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Amount ordered</td>
</tr>
</tbody>
</table>

More Information about Absent Parent

<table>
<thead>
<tr>
<th>Last Known Address</th>
<th>Telephone</th>
<th>Social Security Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alias or Nicknames</td>
<td>Birthdate</td>
<td>Race</td>
</tr>
<tr>
<td>Place of Birth (City, State)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Last Known Place of Employment</td>
<td>Dates of Employment:</td>
<td></td>
</tr>
<tr>
<td>Name of Absent Parent’s Father</td>
<td>Name of Absent Parent’s Mother</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Child with Absent Parent: Child # 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child’s Name</td>
</tr>
<tr>
<td>City:</td>
</tr>
<tr>
<td>Was this child born at full term? Yes ☐ No ☐</td>
</tr>
<tr>
<td>If no, at how many weeks was this child born?</td>
</tr>
</tbody>
</table>

I certify that Child #2 listed above was conceived as a result of sexual intercourse with the alleged parent I have listed at the location I listed above.

Signature:

December 2015
### Paternity Established?

<table>
<thead>
<tr>
<th>Voluntary Support</th>
<th>Court-Ordered Child Support</th>
</tr>
</thead>
<tbody>
<tr>
<td>Has paternity been established?</td>
<td>Date you last received money from the Absent Parent</td>
</tr>
<tr>
<td>Yes ☐ No ☐</td>
<td>Court</td>
</tr>
<tr>
<td>If so, by what means?</td>
<td>Date ordered</td>
</tr>
<tr>
<td></td>
<td>City, State</td>
</tr>
<tr>
<td></td>
<td>Amount ordered</td>
</tr>
</tbody>
</table>

#### More Information about Absent Parent (complete this if different from Child #1)

<table>
<thead>
<tr>
<th>Last Known Address</th>
<th>Telephone</th>
<th>Social Security Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alias or Nicknames</td>
<td>Birthdate</td>
<td>Race</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Place of Birth (City, State)</td>
</tr>
<tr>
<td>Last Known Place of Employment</td>
<td>Dates of Employment:</td>
<td></td>
</tr>
<tr>
<td>Name of Absent Parent’s Father</td>
<td>Name of Absent Parent’s Mother</td>
<td></td>
</tr>
</tbody>
</table>

### Child with Absent Parent: Child #3

<table>
<thead>
<tr>
<th>Child’s Name</th>
<th>Date of Birth</th>
<th>In what city and state was this child conceived?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>City: State:</td>
</tr>
<tr>
<td>Was this child born at full term?</td>
<td>Yes ☐ No ☐</td>
<td>Name of Alleged Absent Parent</td>
</tr>
<tr>
<td>If no, at how many weeks was this child born?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

I certify that Child #3 listed above was conceived as a result of sexual intercourse with the alleged parent I have listed at the location I listed above.

Signature:

#### Paternity Established?

<table>
<thead>
<tr>
<th>Voluntary Support</th>
<th>Court-Ordered Child Support</th>
</tr>
</thead>
<tbody>
<tr>
<td>Has paternity been established?</td>
<td>Date you last received money from the Absent Parent</td>
</tr>
<tr>
<td>Yes ☐ No ☐</td>
<td>Court</td>
</tr>
<tr>
<td>If so, by what means?</td>
<td>Date ordered</td>
</tr>
<tr>
<td></td>
<td>City, State</td>
</tr>
<tr>
<td></td>
<td>Amount ordered</td>
</tr>
</tbody>
</table>

#### More Information about Absent Parent (complete this if different from Child #1 and #2)

<table>
<thead>
<tr>
<th>Last Known Address</th>
<th>Telephone</th>
<th>Social Security Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alias or Nicknames</td>
<td>Birthdate</td>
<td>Race</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Place of Birth (City, State)</td>
</tr>
<tr>
<td>Last Known Place of Employment</td>
<td>Dates of Employment:</td>
<td></td>
</tr>
<tr>
<td>Name of Absent Parent’s Father</td>
<td>Name of Absent Parent’s Mother</td>
<td></td>
</tr>
</tbody>
</table>

I solemnly swear or affirm under criminal penalties for the making of a false statement that I have read the foregoing information regarding parents absent from the home and that the factual statements made in it are true to the best of my personal knowledge, information and belief.

I understand and agree that the Child Support Services Division (CSSD) will collect all child support payments. Since I am assigning support rights, I also agree to repay CSSD any payments that are made to me.

SIGNATURE: X ____________________________ DATE: ____________________________

December 2015
### Health Insurance and Medical Bills
(Medical Assistance Only)

You may still get Medical Assistance even if you have other health insurance. We can also pay your Medicare premiums for you. Please tell us about your health insurance.

<table>
<thead>
<tr>
<th>Medicare</th>
<th>Does anyone have Medicare (a red, white and blue card)?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>If YES, who has Medicare? ____________________________</td>
</tr>
<tr>
<td></td>
<td>□ Yes □ No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Health Insurance</th>
<th>Does anyone have any other insurance?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>If YES, please give us a copy of the insurance card.</td>
</tr>
<tr>
<td></td>
<td>□ Yes □ No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Retro Medicaid/ Medical Bills</th>
<th>Did anyone have any medical bills in the last three months?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>If you get DC Medicaid, you can get paid back for some bills that you have paid. We can also pay some unpaid bills. Call (202) 698-2009.</td>
</tr>
<tr>
<td></td>
<td>Were your address, income, and assets the same as now during the last three months? If no, describe the change.</td>
</tr>
<tr>
<td></td>
<td>□ Yes □ No</td>
</tr>
</tbody>
</table>

### 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

**Note:** You may check more than one race. Also, you do not have to provide this information. None of this information will affect your benefits. We only ask for this information to make sure that we do not discriminate.

### Language Preference

The DC Language Access Act requires that we provide services for persons who do not speak English or cannot speak English well. The law also requires that we collect information on the languages that our customers use. Please answer the following questions:

**What is the Language that you usually speak?**

□ English □ Spanish □ French □ Vietnamese □ Korean □ Amharic □ Chinese (Mandarin) □ Chinese (Cantonese) □ Other ____________________________

**What Language do you want to use to get ESA services?**

□ English □ Spanish □ French □ Vietnamese □ Korean □ Amharic □ Chinese (Mandarin) □ Chinese (Cantonese) □ Other ____________________________

If you do not want to use the language that you usually speak, you must sign the statement below:

I have been told that I have the right to receive ESA services in the language that I usually speak. By signing below, I am saying that I do NOT want language services.

**Sign here only if you do NOT want language services:** ____________________________

December 2015
Many immigrants are eligible for benefits. For any non-citizen applying for benefits, please provide the immigration information below. If your status is "OTHER," then we will not ask you for any more information about your immigration status.

If you are only applying for your child, you do not have to give details about your immigration status. Instead, you can just give your child’s immigration information. If you just want benefits for your child, you can mark “OTHER” for your own immigration status.

We may ask Immigration Services (USCIS) to verify the status of anyone who is NOT listed as “OTHER”. This may affect your eligibility for benefits and the amount of your benefits.

Please use these categories for "Current Status" in the table below:

- 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 one year
- Alien who has been present before April 1, 1980, as a “Conditional Entrant”
- Person on active duty in U.S. Armed Forces (or veteran)
- Spouse, widow or dependent of American soldier or veteran
- A victim of domestic violence
- A victim of a severe form of trafficking in human persons
- Native American/Inuit born outside of the U.S.
- Hmong/Laotian
- Afghan/Iraqi Special Immigrant
- Amerasians who came to the U.S. due to the Vietnam War
- OTHER: status does NOT match one of those listed here.

<table>
<thead>
<tr>
<th>Name</th>
<th>Alien ID # (<em>A</em> number)</th>
<th>Current Status</th>
<th>Date that You Moved to the U.S.</th>
<th>Was ever a Refugee/Asylee?</th>
<th>Cuban/Haitian?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
<td></td>
<td></td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>2.</td>
<td></td>
<td></td>
<td></td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>3.</td>
<td></td>
<td></td>
<td></td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>4.</td>
<td></td>
<td></td>
<td></td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>5.</td>
<td></td>
<td></td>
<td></td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

**Important:** Did anyone above move to the United States before August 22, 1996?  

- Yes  
- No

If YES, who?  

**For Lawful Permanent Residents (LPRs) only:**

Note: Some immigrants who moved to the U.S. after August 22, 1996 do not have to wait five years before getting benefits.

1. Do you have a sponsor?  
   - Yes  
   - No

2. Have you, your parents, your spouse, and/or your sponsor ever worked in the U.S.?  
   - Yes  
   - No

December 2015
The date stamp at the right shows that DHS got your application. If you have any questions, you can call the ESA Call Center on (202) 727-5355.

Your worker will give you a "checklist." This checklist tells you which documents that you need to bring back to DHS. You can also mail copies to your Service Center at the address recorded below. If you mail them, please write your name and your date of birth on each document. DHS must help you get the documents you need, when you are not able to get them. Let us know if you need help.

ESA Contact: ____________________________   Tel: _____________________
Service Center address: _____________________________________________

**Documents That You May Need to Bring to DHS**

<table>
<thead>
<tr>
<th>Proof of:</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income</td>
<td>Recent paystubs; statement showing retirement income, disability income, or Workers Compensation; pension statement; etc.</td>
</tr>
<tr>
<td>Assets</td>
<td>Recent bank and checking account statements, etc.</td>
</tr>
<tr>
<td>DC Residency</td>
<td>DC driver’s license, lease, rent receipt, written statement from your landlord, utility or telephone bill, etc.</td>
</tr>
<tr>
<td>Social Security Number</td>
<td>Social Security card; tax or payroll documents with your SSN on it; DC driver’s license with your SSN on it; etc. (Not required for Food Stamp-only applicants.)</td>
</tr>
<tr>
<td>Medical Exam Report/Disability</td>
<td>Recent medical report (or Form 856) and any supporting materials from your doctor.</td>
</tr>
<tr>
<td>Immigration Information</td>
<td>Employment Authorization card, I-94, visa, passport, or other documents from the INS.</td>
</tr>
<tr>
<td>Rent/Mortgage (Food Stamps only)</td>
<td>Lease, rent receipt, cancelled check, mortgage statement, etc.</td>
</tr>
<tr>
<td>Utility Bills (Food Stamps only)</td>
<td>Recent bills for electric, gas, fuel, phone, water, telephone, etc. (if you pay these separately from your rent).</td>
</tr>
<tr>
<td>Relationship (TANF only)</td>
<td>Birth certificate (full copy) for your child(ren) or official records from a school, court, hospital, etc.</td>
</tr>
<tr>
<td>“Living with” (TANF only)</td>
<td>Statements from two non-relatives or school records.</td>
</tr>
</tbody>
</table>

Also bring your Medicare card or other health insurance card, if you have one.

**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 (202) 639-4030.
- WIC is a program for children under five. With WIC, you can **save up to $140** each month on food. Also, WIC staff can talk with you about breast-feeding. To find out more, call 1-800-345-1WIC (1-800-345-1942).
- If you are eligible for DC Medicaid, you can get money back for **recent medical bills** that you have paid. To find out more, call (202) 698-2009.
- The District has a special program for seniors and the disabled who need **in-home nursing** and other home care. This program has a higher income limit than regular Medical Assistance. To find out more, call 1-877-919-2372.

<table>
<thead>
<tr>
<th>HIV/AIDS testing and services</th>
<th>(202) 671-4900</th>
<th>Medicare</th>
<th>1-800-633-4227</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol and drugs</td>
<td>1-888-7WE-HELP</td>
<td>Social Security Administration</td>
<td>1-800-772-1213</td>
</tr>
<tr>
<td>Depression and mental health</td>
<td>1-888-7WE-HELP</td>
<td>Energy Assistance</td>
<td>(202) 673-6700</td>
</tr>
<tr>
<td>Breast/cervical cancer screening</td>
<td>(202) 442-5900</td>
<td>Public Housing and Section 8</td>
<td>(202) 535-1000</td>
</tr>
</tbody>
</table>

December 2015
Free Legal Help

<table>
<thead>
<tr>
<th>Neighborhood Legal Services</th>
<th>Bread for the City Legal Clinics</th>
<th>Legal Clinic for the Homeless</th>
</tr>
</thead>
<tbody>
<tr>
<td>680 Rhode Island Ave., NE</td>
<td>1640 Good Hope Rd., SE</td>
<td>1200 U St., NW</td>
</tr>
<tr>
<td>(202) 832-6577</td>
<td>(202) 561-8587</td>
<td>(202) 328-5500</td>
</tr>
<tr>
<td>4609 Polk St., NE (Ward 7)</td>
<td>1525 Seventh St., NW</td>
<td>Legal Counsel for the Elderly</td>
</tr>
<tr>
<td>(202) 832-6577</td>
<td>(202) 265-2400</td>
<td>(for people age 60 and older)</td>
</tr>
<tr>
<td>2811 Pennsylvania Ave., SE (Ward 8)</td>
<td>Legal Aid Society</td>
<td>601 E St., NW</td>
</tr>
<tr>
<td>(202) 832-6577</td>
<td>666 11th St., NW, Suite 800</td>
<td>(202) 434-2120</td>
</tr>
</tbody>
</table>

Your Rights and the Program Rules

Recertification

We will send you a recertification notice in the mail. If you get Medical Assistance, just complete the form and send it back to DHS. If you get Food Stamps or cash assistance (TANF, GC or IDA), then you will need to come to DHS for an interview. If you do not recertify, then you will lose your benefits. Also, please let us know if you move. Just call (202) 727-5355 to report your new address.

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.

Your case may be chosen for a Quality Control review. This is a detailed review of all of your information. It may include 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. If a food stamp claim arises against you, the information on this form, including SSNs, may be sent to Federal and State offices, or private claims collection agencies for claims collection action against all adults in the household.

Under federal and District law, you must provide your Social Security Number (if you have one) if you are in the assistance unit. (See 42 CFR 435.910, 7 CFR 273.6, DC Code §4-204.07, §4-205.05a, and §4-217.07) Your SSN will be used to verify your identity, prevent receipt of duplicate benefits, and make required program changes. The DHS computer system uses your SSN to verify your income by using records from federal and local sources, including the Internal Revenue Service, the Social Security Administration, DC Department of Employment Services, and the DC Child Support Services Division (CSSD). DHS also reserves the right to check your information with income verification services and other local agencies.

Unless you receive a notice of simplified reporting, you must report changes in your income, assets, shelter and childcare costs, and who lives with you. To report a change, call (202) 727-5355. You must call us before the 10th day of the month after the change.

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.

Medical Assistance Rules

The Medicaid rules have changed. If you are not aged (over 65), blind, or disabled, you must complete the new DC Health Link application for medical insurance. However, if you are over 65, blind or disabled or if you want us to review your application for Interim Disability Assistance, then you must complete this form. After you apply, you will get a decision about your Medical Assistance within 45 days (or 90 days if DHS must determine if you are disabled). If you do not get a notice within this period, please call (202) 727-5355.

If you get Medical Assistance, then you must recertify each year when we send you a recertification notice. There is no time limit for getting Medical Assistance. Also, if you lose TANF, you may still get Medical Assistance.

Child Support: You agree to cooperate fully with the DC Child Support Services Division (CSSD) in establishing paternity and getting child and medical support as required by law. You can apply for an exception to this if you have a good reason. However, you can lose your benefits if you do not cooperate without a good reason.

Estate Recovery: The District will seek recovery for the bills we pay if you are in a nursing home or other medical institution. Also, if you are age 55 or older, the District will seek recovery for services that you get. This means that we may put a lien or claim on your property or estate.

You can also get free legal help for a Fair Hearing. Call one of the agencies above to talk to a lawyer or counselor.

December 2015
*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.

*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:*
b. Terris Pravlik & Millian, LLP, 1121 12th Street, NW, Washington, DC 20005, (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) 442-0904. 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 1121 12th Street, NW; Washington, DC 20005 or (202) 682-0578.

**TANF Rules**

There are new requirements in the TANF program. After you apply, you must complete an orientation, assessment and develop an initial self sufficiency plan as a condition of eligibility for TANF benefits. This requirement does not apply to you if you are receiving SSI or if you are caretaker of child(ren) that are not yours and you are only applying for the child(ren). To schedule an appointment for an assessment, you can call the Family Resource Center at (202) 698-1860. You will get a decision about your TANF within 45 days. If you do not get a notice within 45 days, you can get a Fair Hearing. Also, if you think your benefit amount is incorrect, then you can get a Fair Hearing.

If you are able to work, then you must comply with the work requirements to receive TANF benefits. You could lose your benefits if you do not comply. If you have a physical or mental condition that keeps you from working, let DHS case coordinator know at any time. You can be excused from working if you have a good reason. This is called a work exemption.

You are excused from working if:
- You are a minor parent and you are in school
- You have a child under 6 and cannot find child care
- You are incapacitated, injured or have a disability
- You are required to take care of someone in your house who is ill or disabled
- You are 60 years of age or older
- You need treatment for substance abuse and you cannot work
- You are a victim of domestic violence and you are afraid for your safety
- You have a child under one (1) years old

We may ask for proof of your need to be excused, including a report from your doctor where appropriate. If you are eligible for the exemption, you may also be eligible for a temporary transfer to POWER.

**POWER:** You can apply for a temporary transfer to POWER at any time if you are eligible for TANF benefits but cannot work. You can apply for POWER by letting us know that you have a physical or mental condition that prevents you from working. You can also be eligible for POWER if you are:
- A minor parent enrolled in school
- You are required to take care of someone in your house who is ill or disabled
- You are 60 years of age or older
- You need treatment of substance abuse and you cannot work
- You are a victim of domestic violence and you are afraid for your safety

December 2015
Child Support: There are new rules for Child Support. You can receive both TANF and a portion of your child support at the same time. The Child Support Services Division can help you get child support from the other parent. You are required by law to cooperate with the CSSD. Contact (202) 442-9900 to set up an appointment with them. By signing this application, you agree to cooperate fully with the CSSD in establishing paternity and getting child and medical support as required by law. You can ask for an exemption if you have a good reason for not cooperating.

You have a good reason if:
- You are afraid that you, your children, or a close family member could be harmed if you help CCSD
- Your child was conceived because of rape by a stranger, someone you know, or a relative
- Your child is going to be adopted or you are deciding whether to give up your child for adoption

You may have other reasons for not wanting to help CSSD. Discuss them with your Child Support Worker. If you have a good reason, tell your DHS and Child Support Worker and provide proof within 20 days of the request for exemption. After you provide proof to CSSD, they will let you know of their decision. If you do not cooperate with CSSD, and you do not have an exemption, then you will lose 25% of your TANF benefit.

TANF Time Limits: Most people can only get TANF for 60 months. We count every month that you received a TANF benefit until you get to 60 months. If you are subject to the time limits, your TANF benefit will be reduced or eliminated at the beginning of 61 months.

You are not subject to the time limits if you are receiving SSI or if you are receiving TANF because you are caring for someone else’s child. In addition, the months do not count if you are receiving POWER benefits. It is important that you let us know if you are having trouble working because of illness or disability. You may qualify for POWER for other reasons. Please see the section on POWER for more information.

Work Pays While on TANF: When you report that you got a job, you may be eligible to receive up to $1,250 in TANF bonuses while you work! We also discount your income so that you can keep more of your TANF while you are bringing home a paycheck. How much of your TANF money you keep depends on how much you are earning.

Sanctions: If you do not follow your plan or work requirements, your TANF benefits will be cut, unless you have a good reason. This is called a work sanction. We want you to put yourself in the best situation to be successful for you and your children. DHS offers services to assist you with preparing for and getting a job, address problems that are preventing you from being successful at a job, and help with getting a better job. If you are at risk of a sanction, we will notify you in advance. You can avoid sanctions. Contact your case manager or DHS Family Resource Center to learn how.

December 2015
**IDA Rules**

After you apply, you will get a decision about your IDA within 60 days. If you do not get a notice within 60 days, you can get a Fair Hearing. Also, if you do not think your benefit amount is correct, then you can get a Fair Hearing.

If you get IDA, then you must cooperate with your IDA case manager. This means:

- Give us medical reports and other materials;
- Keep your appointments with the doctor and with the Social Security Administration;
- Keep your appointments with your case manager; and
- Go to treatment programs, as required.

If you do not follow these rules, then you may lose part or all of your IDA benefits. Also, DHS will take out the amount of IDA that you got from your first “lump sum” SSI check; DHS will send the rest of your first SSI check to you.

**Rights of Support**

You must turn over to the District Government any payments that you get from an insurance company for medical care. You must turn over part or all of your child support to the DC Child Support Services Division (CSSD) after you get your first TANF payment. If you do not agree to these conditions, then you cannot get Medicaid or TANF. Once you are off TANF, then you can keep any current child support payments. If you use a Medicaid card or the TANF benefit, then you are telling us that you agree to these conditions.

**Confidentiality**

By applying, you give DHS permission to talk with your employer, your landlord, 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. Of course, DHS keeps all of your information confidential. DHS does not release your records without your permission (except when required by law).

**Equality and Non-Discrimination**

This institution is prohibited from discriminating on the basis of race, color, national origin, disability, age, sex and in some cases religion or political beliefs.

The U.S. Department of Agriculture also prohibits discrimination based on race, color, national origin, sex, religious creed, disability, age, political beliefs or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits.

December 2015
ESA Combined Application
December 2015