DC Healthy Families

Because some of the best things in life are free.

Call us if you do not speak or read English.

Amharic:	እንግሊዝኛ መናገር ወይም ማንበብ የማይቻሉ ከሆነ ይደውሉልን.
Chinese:	如果您不會講英語或不會閱讀英語，請打電話告訴我們。
French:	Appelez-nous si vous ne parlez pas ou ne savez pas lire l'anglais.
Korean:	영어로 말하거나 읽는데 어려움이 있으면 전화주십시오.
Spanish:	Llámenos si no habla ni lee inglés.
Vietnamese:	Hãy gọi chúng tôi nếu quý vị không nói hoặc đọc tiếng Anh.

Fee-for-Service Continuation Form

If you or your child has HIV/AIDS, you can stay in the DC Medicaid program instead of enrolling in a DC Healthy Families health plan. That way, you can continue seeing your primary care doctor or specialist. You don't have to change doctors if you don't want to.

If you or your child has HIV/AIDS, fill out and return this form immediately.

1. PATIENT: (please print)

Name _____ Birth date_____

Social Security Number_____ Medicaid Number_____

Phone number_____ Alternate phone _____

Signature_____ Date_____

At this time, I do not want to enroll in one of the DC Healthy Families Medicaid Managed Care health plans because: ☐ HIV/AIDS exemption. I am HIV+ or have a diagnosis of AIDS.

➔ **IMPORTANT!**
Take this form to your doctor.
Have them sign it and send it back to us.

2. DOCTOR:

I certify that _____is my patient and is under my care for HIV/AIDS.

Doctor's name_____ Phone #_____

Signature _____ Date_____

3. RETURN THIS FORM IMMEDIATELY BY MAIL OR FAX TO:

Management Analyst
Division of Managed Care
Department of Health Care Finance
One Judiciary Square
441 4th Street, NW, Suite 900 South
Washington, DC 20001

Fax: 202-478-1379 or 1397