DC Healthy Families
Because some of the best things in life are free.

DCHealthCare Alliance

DHCF

GOVERNMENT OF THE DISTRICT OF COLUMBIA
MURIEL BOWSER, MAYOR

Call us if you do not speak or read English.

Amharic: እንግሊዝኛ መናገር ወይም ማንበብ የሚቻሉ 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.

Health Plan Selection Form

You get to choose a health plan, a doctor and a dentist for yourself and your family members.

HERE ARE THE WAYS YOU CAN ENROLL

(202) 639-4030 or (800) 620-7802
Call us if you need help in any language.
TTY/TDD Line: (202) 639-4041

Mail this form back to us.
There's an envelope enclosed;
no stamp is needed.

www.DCHealthyFamilies.com
Fill out this form online. It's fast and easy.

Watch a video about
how to select a health plan.

STEP 1: Head of Household Information

Name:		Birth date: (mm/dd/yyyy) / /
Home address:		
Home phone: ( ) —	Cell phone: ( ) —	E-mail:
Language you speak at home: ☐ English ☐ Spanish ☐ Amharic ☐ Chinese ☐ French ☐ Korean ☐ Vietnamese ☐ Other: _____		
Member ID #:		Social Security #: — —
Pick a plan: ☐ AmeriHealth ☐ CareFirst CHPDC ☐ MedStar FC DC		Name of doctor:
		Name of dentist:

STEP 2: Family Member Information

If you need more space to write, use another piece of paper and send it in with your form.

Provide information and select a health plan for each family member who qualifies for DC Healthy Families or DC HealthCare Alliance.

Name:	Name:
Birth date: (mm/dd/yyyy) / /	Birth date: (mm/dd/yyyy) / /
Medicaid #:	Medicaid #:
Social Security #: — —	Social Security #: — —
Pick a plan: ☐ AmeriHealth ☐ CareFirst CHPDC ☐ MedStar FC DC	Pick a plan: ☐ AmeriHealth ☐ CareFirst CHPDC ☐ MedStar FC DC
Name of doctor:	Name of doctor:
Name of dentist:	Name of dentist:

Name:	Name:
Birth date: (mm/dd/yyyy) / /	Birth date: (mm/dd/yyyy) / /
Medicaid #:	Medicaid #:
Social Security #: — —	Social Security #: — —
Pick a plan: ☐ AmeriHealth ☐ CareFirst CHPDC ☐ MedStar FC DC	Pick a plan: ☐ AmeriHealth ☐ CareFirst CHPDC ☐ MedStar FC DC
Name of doctor:	Name of doctor:
Name of dentist:	Name of dentist:

Signature: _____ Date: / /

IMPORTANT! *You must sign and date this form before you send it back.*

DC Healthy Families, 1111 14th Street NW, Suite 620, Washington, DC 20005
Phone: (202) 639-4030 or (800) 620-7802 Fax: (202) 289-6764 Web: www.DCHealthyFamilies.com
Office Hours: Monday, Tuesday, Thursday, and Friday: 8:00 a.m. – 7:00 p.m. – Wednesday: 8:00 a.m. – 9:00 p.m.
Third Saturday of each month: 9:00 a.m. – 1:00 p.m.

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