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

DHS Form 30-AW:
Medicaid Waiver Enrollment Request/Update

Last Name: _____

First Name: _____

Suffix (Sr., Jr., etc): _____

DOB: _____

SSN: _____

Sex: _____

Race: _____

Marital Status: _____

Citizenship: _____ Alien ID# A_____ (if appl.)

Medicare: ☐ Yes, Medicare #_____ ☐ No

Program Code: 853___

Eligibility Start Date: _____

Eligibility End Date: _____

Level-of-Care: ☐ Yes, meets to Level-of-Care ☐ No

☐ Level-of Care is forthcoming ☐ N/A

Other Case Action or Change Request (including requests for denial notices):

_____

_____

Notes:

- New cases, including a complete, signed Combined Application and all verifications, may be sent to the IMA Medicaid Branch, 645 H St., NE, Washington, DC 20002.
- Recertifications or change requests may be faxed to the IMA Medicaid Branch.
- Denial notices (e.g., because customer did not meet level-of-care, etc.) should be explicitly requested in the "Other Case Action or Change Request" section.

_____ _____

Signature Title

_____ _____

Date Telephone