

**DC Healthy Families  
Fee-for-Service Continuation Form**

**Vea al dorso para la  
version en Español**

**Purpose:** The Fee-for-Service Continuation Form is to give those individuals who have HIV/AIDS the option of not enrolling into a health plan. This group is likely to have developed an on-going personal relationship with a primary care doctor or specialist who would be responsive to their particular needs. The idea is not to interrupt that care especially if the primary care doctor is not in managed care. Individuals with HIV/AIDS have the option to remain in straight Medicaid.

**What to Do:** If you or your child has HIV/AIDS, then you must:

- Complete **Sections 1 and 2** of this form
- Take this form to your doctor and have your doctor complete sections 3 and 4

***That is all you have to do to use this option. However, you must do it now!***

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1. At this time, I do not have to enroll in one of the DC Healthy Families Medicaid Managed Care health plans (HMO) because:

**HIV/AIDS EXEMPTION** – I am HIV+ or have AIDS *(Have doctor sign below)*

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2. **PATIENT VERIFICATION:**

Name (please print) \_\_\_\_\_ Birth date \_\_\_\_\_

Medicaid Number \_\_\_\_\_ Social Security Number \_\_\_\_\_

Phone number \_\_\_\_\_ Alternate phone number \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

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3. **MEDICAL VERIFICATION:**

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

Doctor's name \_\_\_\_\_ Phone # \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

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4. **PLEASE RETURN THIS FORM BY MAIL OR FAX TO:**

*Elisa Fauntleroy, Medical Assistance Administration, 825 North Capitol St., N.E., Rm. 5135, Washington, D.C. 20002. Fax Number: 202-478-1379*