Application For Retroactive Medical Assistance

You may apply for retroactive medical assistance for the three month periods immediately prior to the date in which the completed and signed DFA Form 800, *Application for Assistance*, or DFA Form 800MA, *Application for Health Coverage & Help Paying Costs,* is received by DHHS. The three month periods are referred to as retroactive periods. (For example, if the application is received by the District Office on May 12, you could apply for medical assistance for the retroactive periods of April 12 - May 11; March 12 - April 11; February 12 - March 11.) If you apply, you will receive medical assistance for each retroactive period in which you met all financial and non-financial eligibility requirements.

Please Note

- You do not have to be currently eligible to apply for retroactive medical assistance.
- If you need retroactive medical assistance, you are encouraged to apply at this time. However, if you find out later that you need this coverage, you may apply for it up to nine months from the first date of the retroactive period for which you are requesting medical assistance.
- You must provide the same kind of information for the retroactive periods that is required for your current application.
- If you have already paid (partially or in full) for a medical service or item provided in an eligible retroactive period, ask your Family Services Specialist to explain how DHHS may pay for these services.

How To Apply

If you would like to apply for retroactive medical assistance for any or all of the three month periods immediately prior to the date your completed and signed application is received, please sign the statement below and return the bottom portion of this form to the District Office. You may keep the top portion of this page for your information.

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Request For Retroactive Medical Assistance

The provisions for retroactive medical assistance have been explained to me and I would like to apply for medical assistance for one or more of the three periods prior to the date my completed and signed DFA Form 800, *Application for Assistance*, or DFA Form 800MA, *Application for Health Coverage & Help Paying Costs*, was received by DHHS.

The retroactive periods for which I would like medical coverage are:

_____, _____, _____

I realize that I may be asked to provide verification of eligibility information for each retroactive period listed above and that, if I am eligible, DHHS will pay only for those services and items covered by the Medical Assistance Program, up to the charge allowed.

APPLICANT'S NAME (PLEASE PRINT)

APPLICANT'S SIGNATURE
(If applicant is unable to sign, the person representing the applicant.)

DATE

Detach And Return This Bottom Portion To Centralized Scanning Unit (CSU), P.O. Box 181, Concord, NH 03301