State of Hawaii
Department of Human Services
Med-QUEST Division

Application Date: _____
Date Sent: _____
Due Date: _____

Supplemental Form for Individuals Applying for Coverage on the basis of Age, Blindness or Disability and/or Requests for Long-Term Care Services
(Supplement to Form DHS 1100)

The information on this supplemental form provides additional information to form DHS 1100, "Application for Health Coverage & Help Paying Costs", necessary to process an application for individuals who may be eligible for coverage on the basis of Age, Blindness or Disability and/or requests for long-term care (LTC) services.

Name: _____

Address: _____

_____

If more space is needed for your responses, please attach a separate sheet of paper to this supplemental form.

A. Tell us who needs LTC services.

1. First name, Middle initial, Last name, & Suffix

2. Date of Birth (mm/dd/yyyy) / /

3. Have you been certified as blind or disabled (i.e., receiving Supplemental Security Income (SSI) or Social Security blind/disabled benefits)?

☐ No If no, you may be required to complete additional forms.
☐ Yes

4. Where do you have/want to have LTC services provided to you?

☐ At Home-Address: _____ Service Start Date: _____

☐ Nursing Facility Name: _____ Admission Date: _____

☐ Community Care Foster Family Home Name: _____ Admission Date: _____

5. Marital Status: ☐ Single ☐ Divorced ☐ Widow(er) ☐ Married

B. Tell us who your spouse and/or dependent(s) under age 18 living with you.

1. **Spouse's** First name, Middle initial, Last name, & Suffix

Date of Birth (mm/dd/yyyy) / / Social Security Number Gender: ☐ Male ☐ Female

2. **Dependent #1:** First name, Middle initial, Last name, & Suffix

Date of Birth (mm/dd/yyyy) / / Social Security Number Gender: ☐ Male ☐ Female

3. **Dependent #2:** First name, Middle initial, Last name, & Suffix

Date of Birth (mm/dd/yyyy) / / Social Security Number Gender: ☐ Male ☐ Female

C. Tell us about yourself, your spouse and your dependent(s) income, assets, health insurance and medical expenses.

1. Do you, your spouse or dependent(s) receive the following income? Check YES or NO for every type of income listed below. If you receive other income not previously reported to us, check YES for Other Income and state type of income it is.

☐ No
☐ Yes If yes, provide the following information.

YES	NO	INCOME TYPE	PERSON RECEIVING INCOME	MONTHLY AMOUNT
☐	☐	Child Support		$
☐	☐	Supplemental Security Income (SSI)		$
☐	☐	Worker's Compensation		$
☐	☐	Veterans Administration Income (VA)		$
☐	☐	Other Income: _____		$

2. Do you, your spouse or dependent(s) own any assets? Check YES or NO for every type of asset listed below. If your assets are not on this list, check YES for Other Assets and state type of asset it is.

☐ No
☐ Yes If yes, please provide the following information as of the first day of this month.

YES	NO	ASSETS	OWNER'S NAME	BANK OR COMPANY NAME	EQUITY VALUE
☐	☐	Checking Accounts (List all)			$
☐	☐	Savings Accounts (List all)			$
☐	☐	Cash			$
☐	☐	Income Tax Refunds			$
☐	☐	Stocks and Bonds			$
☐	☐	Money Market Accounts, CDs, and Time Certificates			$
☐	☐	IRA, Keogh, and Deferred Compensation			$
☐	☐	Burial Plans: Total No. _____			$
☐	☐	Burial Plots: Total No. _____			$
☐	☐	Life Insurance (Surrender Cash Value)			$
☐	☐	Family or Individual Trust or Trust Funds			$
☐	☐	Business Equity (Self-Employed)			$
☐	☐	Boats and Trailers			$
☐	☐	Jewelry, Diamonds, Gold, Silver, Etc.			$
☐	☐	Other Assets: _____			$

3. Do you, your spouse or dependent(s) have dental insurance, vision insurance, Medicare, TRICARE, VA benefits, other health insurance or prescription drug coverage? Other health insurance also includes Long-Term Care Insurance where it pays for Nursing Facility services. (The other health insurance may help pay for the cost of your health coverage.)

☐ No
☐ Yes If yes, please provide the following information.

PERSON COVERED	NAME OF INSURANCE COMPANY	TYPE OF COVERAGE	POLICY NUMBER	EFFECTIVE DATE (mm/dd/yy)	MONTHLY PREMIUM AMOUNT
					$
					$
					$

4. Do you, your spouse or dependent(s) need help with any unpaid medical bills in the past 3 months? (We may be able to help pay your medical bills.)

☐ No
☐ Yes If yes, please provide the following information.

PERSON WITH BILL	NAME OF PROVIDER (Doctor, Clinic, Hospital, etc.)	SERVICE DATES

5. Do you and/or your spouse own a home property that you currently reside in? (You may need to complete additional forms.)

☐ No
☐ Yes If yes, please provide the following information.

OWNER'S NAME	PROPERTY ADDRESS	EQUITY VALUE
		$
		$
		$

6. Do you and/or your spouse own other properties other than your home property?

☐ No
☐ Yes If yes, please provide the following information.

OWNER'S NAME	PROPERTY ADDRESS	MARKET VALUE
		$
		$
		$

7. Did you and/or your spouse purchase life estate interest in a property of another?

☐ No
☐ Yes If yes, please provide the following information.

OWNER'S NAME	TRANSACTION DATE	ADDRESS OF PROPERTY WITH LIFE ESTATE INTEREST	AMOUNT PAID
			$
			$

8. Did you and/or your spouse sell, trade, give away money, property, or other assets in the past 60 months? Or did you and/or your spouse make transfers into a trust within the past 60 months?

☐ No
☐ Yes If yes, please provide the following information.

ITEMS SOLD, TRADED, ETC.	TRANSACTION DATE	REASON FOR SALE, TRANSFER, ETC.	ACTUAL VALUE OF ITEMS	AMOUNT RECEIVED
			$	$
			$	$
			$	$

9. Do you and/or your spouse own any annuities? (You may be asked to complete additional forms.)

☐ No
☐ Yes If yes, please provide the following information.

OWNER'S NAME	ISSUANCE DATE	NAME AND ADDRESS OF ANNUITY COMPANY

10. Do you and/or your spouse have a promissory note, loan, or mortgage?

☐ No
☐ Yes If yes, please provide the following information.

PROMISSORY NOTE, LOAN OR MORTGAGE	OWNER'S NAME	TRANSACTION DATE	ORIGINAL AMOUNT	BALANCE OWED
Promissory Note			$	$
Loan			$	$
Mortgage			$	$

11. Did you and/or your spouse pay an entrance fee to enter a Continuing Care Retirement Community (CCRC) or Life Care Community (LCC)?

☐ No
☐ Yes If yes, please provide the following information.

OWNER'S NAME	TRANSACTION DATE	NAME AND ADDRESS OF CCRC/LCC	AMOUNT PAID
			$
			$
			$

D. Read and sign this supplemental form.

- I'm signing this supplemental form under penalty of perjury, which means, I've provided true answers to all the questions on this form to the best of my knowledge. I know that I may be subject to penalties under State or Federal law if I intentionally provide false or untrue information.
- I know that I must tell the Department of Human Services if anything changes (and is different than) from what I wrote on my application or this supplemental form. I can visit **www.mybenefits.hawaii.gov** or call toll free **1-800-316-8005** to report any changes. I understand that a change in my information could affect my eligibility.
- I know that under Federal law, discrimination isn't permitted on the basis of race, color, national origin, gender, age, sexual orientation, gender identity, or disability. I can file a complaint of discrimination by visiting **www.hhs.gov/ocr/office/file**.
- I confirm that I'm not incarcerated (detained or jailed).

We need this information to check your eligibility for help paying for health coverage if you choose to apply. We'll check your answers using information in our electronic databases and databases from the Internal Revenue Service (IRS), Social Security Administration, Department of Homeland Security, Department of Labor and Industrial Relations (DLIR) and/or a consumer reporting agency. If the information doesn't match, we may ask you to send us proof.

If I'm Eligible for Medicaid

If I enroll in Medicaid, I am giving the Medicaid agency my rights to pursue and get any money from other health insurance, legal settlements, or third parties.

My Right to Appeal

If I think the Department of Human Services has made a mistake, I can appeal its decision. To appeal means to tell someone at the Department of Human Services that I think the action is wrong, and to ask for a fair review of the action. I know that I can find out how to appeal by contacting someone at **1-800-316-8005**. I know that I can be represented in the process by someone other than myself. My eligibility and other important information will be explained to me.

Sign this supplemental form. The person who filled out **section A** should sign this supplemental form. If you're an authorized representative, you may sign here as long as the **Appendix A** is completed on the next page.

Signature	**Date (mm/dd/yyyy)**

PLEASE RETURN THIS FORM TO THE MED-QUEST ELIGIBILITY OFFICE CHECKED BELOW BY: _____.

MED-QUEST ELIGIBILITY BRANCH OFFICES	
☐ OAHU SECTION-HONOLULU 801 Dillingham Blvd., 3rd Floor Honolulu, HI 96817-4582 Mailing: P.O. Box 3490 Honolulu, HI 96811-3490	☐ KAUAI SECTION-Dynasty Court 4473 Pahee St., Suite A Lihue, HI 96766-2037
☐ OAHU SECTION-KAPOLEI-Kakuhihewa State Bldg. 601 Kamokila Blvd., Room 415 Kapolei, HI 96707-2021 Mailing: P.O. Box 29920 Honolulu, HI 96820-2320	☐ MAUI SECTION-Millyard Plaza 210 Imi Kala St. Ste., 101 Wailuku, HI 96793-1274
☐ EAST HAWAII SECTION 1404 Kilauea Ave. Hilo, HI 96720-4670	☐ MOLOKAI UNIT-State Civic Center 65 Makaena Place Rm. 110 Kaunakakai HI 96748-0169 Mailing: P.O. Box 1619 Kaunakakai, HI 96748-1619
☐ WEST HAWAII SECTION-Lanihau Professional Center 75-5591 Palani Rd., Ste., 3004 Kailua-Kona, HI 96740-3633	☐ LANAI UNIT 730 Lanai Ave., Lanai City, HI 96763 Mailing: P.O. Box 631374 Lanai City, HI 96763-0737

APPENDIX A: Assistance with completing this supplemental form:

- You can choose an authorized representative.
- You can give a trusted person permission to talk about this supplemental form with us, see your information, and act for you on matters related to this supplemental form, including getting information about the status of your application request and signing this supplemental form on your behalf. This person is called an "authorized representative." If you ever need to change your authorized representative, call toll free, **1-800-316-8005**. If you're a legally appointed representative for someone on this supplemental form, submit proof with this form.

1. **Name of authorized representative** (First name, Middle name, Last name, & Suffix)		
2. Mailing Address		3. Apartment or suite number
4. City	5. State	6. ZIP Code
7. ~~Organization Name~~ Relationship:	8. Phone Number	9. ID No. (if applicable)
By signing this form, you will allow this person to sign this supplemental form, get official information about the status of your application, and act for you on all future matters with the Department.		
10. Person listed under section "A" Signature		11.Date (mm/dd/yyyy)

As the **Designated Authorized Representative**, I agree to maintain the confidentiality of any information provided to me by the Department or it's designee and I can be released as the Authorized Representative by signing below:

Signature of Authorized Representative	Telephone	Date
Mailing Address	City / State	Zip code
As applicable, I _____, am a provider or staff member or volunteer of an organization:_____ (PRINT Name of Individual) (PRINT Name of Provider/Organization)		
I understand and agree, as a condition of serving as the Authorized Representative, that I will adhere to the regulations relating to confidentiality of information and the prohibition against reassignment of provider claims as appropriate for a health facility or an organization acting on the facility's behalf, as well other relevant State and Federal laws covering conflicts of interest and confidentiality of information.		

For certified application counselors, navigators, agents, and brokers only: Complete this section if you're a certified application counselor, navigator, agent, or broker filling out this supplemental form for somebody else.

1. Application start date (mm/dd/yyyy)	
2. First name, Middle name, Last name, & Suffix	
3. Organization Name	4. ID No. (if applicable)