

INSTRUCTIONS

DHS 1100 (Rev. 12/17) v.4

APPLICATION FOR HEALTH COVERAGE & HELP PAYING COSTS

PURPOSE:

The DHS 1100, Application for Health Coverage & Help Paying Costs (Rev. 12/17) shall be used as the application for anyone applying for medical assistance. Through this streamlined application process, individuals applying for health coverage can get savings to help pay premium amounts for private health coverage, free coverage through Medicaid or low-cost coverage through the Children's Health Insurance Program (CHIP).

GENERAL INSTRUCTIONS:

The DHS 1100 must be signed by an applicant who is an adult or a responsible household member. If the applicant is a minor, is incapacitated and incapable of acting on his or her own behalf, or is deceased, the applicant may designate a trusted person to act as their Authorized Representative on all matters relating to their application. This includes getting information needed to complete the application and signing of the application on the applicant's behalf.

The Department:

- a) Shall provide assistance to any applicant with the DHS 1100 in person, over the telephone, and online, in a manner that is accessible to individuals with disabilities and those who are limited English proficient, in accordance with the Disabilities Act and by section 504 of the Rehabilitation Act and Title VI of the Civil Rights Act of 1964.

- b) May choose to designate organizations, subject to certification by the department or designee to provide assistance to an applicant with the application process to include but not be limited to :
 - Completion or submission of the DHS 1100 for medical assistance
 - Interaction with the department on the status of the application
 - Assistance with responses to the Department; and
 - Case management following the initial approval and subsequent redeterminations in compliance with federal requirements

- c) Shall establish department-certified application counselors providing assistance to an applicant:
 - 1) A designated web portal exclusively for their use for purposes of providing assistance under HAR §17-1711.1-11;
 - 2) A secure mechanism to ensure they are able to perform only those duties for which they are certified; and
 - 3) Procedures to ensure that an applicant is:
 - Informed of the functions and responsibilities of the certified application counselor;
 - Able to authorize a certified application counselor to receive confidential information regarding the applicant related to the application; and
 - Informed that services provided by the certified application counselor is provided free of charge

You have the right to get this information in an alternate format. You also have the right to file a complaint if you feel you've been discriminated against. Visit <https://humanservices.hawaii.gov> in the Civil Rights Corner under Forms or call the Civil Rights Complaint Officer at 1 (808) 586-4955. TTY users can call 711 Hawaii Relay Services or 1-800-603-1201.

NOTE: An applicant who is unable to complete the entire application must provide his/her name, address and a signature of the applicant or authorized representative. Additional information as determined by the Department may be requested when coverage for long-term care services is being requested.

SPECIFIC INSTRUCTIONS:

Page 1 of 9

STEP 1 Tell us about yourself.

A Contact Person must complete all questions as applicable on page 1 of 9. We need this information so we can follow up with the individual if we have questions about the application and so we can let them know what plans or programs the individual applying for medical assistance qualifies for.

STEP 2 Tell us about your family.

The Contact Person shall provide the information about all family members who live in the household including a spouse/partner, any children living in the household, and anyone else included in the household's federal income tax return even if they're not applying for health coverage.

Your household size and income help determine what programs you qualify for. Read the information at the bottom of page 1 of 9 ("Who do you need to include on this application?") carefully to figure out which people to add in Step 2. The application has space for up to 2 people.

If you have more than 2 people in your household, make copies of pages 4-5 of 9 and complete them for each additional person.

The chart below can help determine who should or shouldn't be included in this section.

| | INCLUDE these people even if they aren't applying for health coverage themselves. | DON'T INCLUDE these people if they want to apply for health insurance, they must fill out a separate application. |
|-------------------------------------|--|---|
| For ADULTS who need coverage | All people who are on the same federal income tax return including: -Any spouse -Any sons or daughters, including step children | Anyone who isn't on the same federal income tax return including: -Any unrelated people who live in the same household -Any sons or daughters who aren't on the same tax return -Any parents or adult siblings, even if they live in the same household |

| | | |
|---------------------------------------|--|--|
| For CHILDREN who need coverage | All people who are on the same federal income tax return , including: -Any parents or stepparents -Any siblings | Anyone who isn't on the same federal income tax return, including: -Any unrelated people who live in the same household -Any parents who live in a difference household |
|---------------------------------------|--|--|

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STEP 2: PERSON 1 Start with yourself

Need health coverage? Complete **all** questions on page 2 of 9.

Don't need health coverage? Complete questions 1-9.

| |
|---|
| <p>Question 7 You can still apply for coverage even if you don't plan to file a federal income tax return: -If you're married and interested in getting a premium tax credit, you'll need to file your federal income tax return jointly with your spouse to get the tax credit. -If you're claimed as a dependent on someone else's tax return, list the names of the tax filer(s). -If you're claimed as a dependent, include how you're related to the tax filer. For example, if you're the child of the tax filer, list "child"</p> |
| <p>Question 10 If you have a physical, mental, or emotional health condition that limits activities like bathing, dressing, or daily chores, or if you live in a medical facility or nursing home, answering "yes" won't increase your health care costs. If you have a disability, you may qualify for free or low-cost coverage.</p> |
| <p>Question 12 If you're not a U.S citizen but have eligible immigration status to get coverage through the Marketplace, check "yes" and provide your document type and document ID number(s) see pages 19-20.</p> |
| <p>Questions 17-18 Ethnicity and race questions are optional. This information will help the U.S Department of Health and human Services (HHS) better understand and improve the health and health care for all Americans. Providing this information won't impact your eligibility for health coverage, health plan options, or costs in any way.</p> |

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STEP 2: PERSON 1 (Continue With Yourself)

We ask about your current income to see if you qualify for help paying for coverage and how much help you can get. Include how much you make in wages and tips before taxes are deducted. You don't have to include amounts taken out of your check by your employer for child care, health insurance, or retirement plans that are "not taxable" (sometimes called "pre-tax deductions").

Job & Income Information

Complete all questions as applicable.

27. If you are self-employed: Fill in the type of work you do and how much net income you'll get this month. Net income means the amount left over after you've taken out business expenses. The amount can be positive or negative. The following expenses can be subtracted from your gross income to get an amount for your net self-employment income.

- Car and truck expenses (for travel during the workday not commuting)
- Employee wages and fringe benefits
- Interest (including mortgage interest paid to banks, etc.)
- Rent or lease of business property and utilities
- Advertising
- Repairs and maintenance
- Deductible self-employment taxes
- Contributions to a self-employed SEP, SIMPLE, or qualified retirement plan
- Property, liability, or business interruption insurance
- Depreciation
- Legal and professional services
- Commissions, taxes, licenses, and fees
- Contract labor
- Certain business travel and meals
- Cost of self-employed health insurance

If there are more people to include, please make a copy of pages 4 and 5 of 9. Complete and attach additional pages to this application as applicable. If not applicable, skip to page 6 of 9.

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STEP 2: PERSON 2

Complete Step 2 PERSON 2 for your spouse/partner and/or children who live with you and/or anyone on your same federal income tax return if you file one.

Does PERSON 2 need health coverage? Complete **all** questions on page 4 of 9.

PERSON 2 doesn't need health coverage? Complete questions 1-12.

PERSON 2 can still apply for coverage even if they do not plan to file a federal income tax return:
-If you're married and interested in getting a premium tax credit, you'll need to file your federal income tax return jointly with your spouse to get the tax credit.
-If you're claimed as a dependent on someone else's tax return, list the names of the tax filer(s).
-If you're claimed as a dependent, include how you're related to the tax filer. For example, if you're the child of the tax filer, list "child".

Question 13 If you have a physical, mental, or emotional health condition that limits activities like bathing, dressing, or daily chores, or if you live in a medical facility or nursing home, answering "yes" won't increase your health care costs. If you have a disability, you may qualify for free or low-cost coverage.

Question 15 If PERSON 2 is not a U.S citizen but have eligible immigration status to get coverage through the Marketplace, check "yes" and provide your document type and document ID number(s) see pages 19-20.

Questions 20-21 Ethnicity and race questions are optional. This information will help the U.S Department of Health and human Services (HHS) better understand and improve the health and health care for all Americans. Providing this information won't impact your eligibility for health coverage, health plan options, or costs in any way.

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STEP 2: PERSON 2

Job & Income Information

Provide information about PERSON 2's current income to see if they're eligible for help paying for health coverage. Include how much PERSON 2 makes in wages and tips before taxes are deducted. You don't have to include amounts taken out of PERSON 2's check by their employer for child care, health insurance, or retirement plans that are "not taxable" (sometimes called "pre-tax deductions").

Complete all questions as applicable.

30. If PERSON 2 is self-employed: Fill in the type of work you do and how much net income you'll get this month. Net income means the amount left over after you've taken out business expenses. The amount can be positive or negative. The following expenses can be subtracted from your gross income to get an amount for your net self-employment income.

- Car and truck expenses (for travel during the workday, not commuting)
- Employee wages and fringe benefits
- Interest (including mortgage interest paid to banks, etc.)
- Rent of lease of business property and utilities
- Advertising
- Repairs and maintenance
- Deductible self-employment taxes
- Contributions to a self-employed SEP, SIMPLE, or qualified retirement plan
- Property liability or business interruption insurance
- Depreciation
- Legal and professional services
- Commissions, taxes, licenses, and fees
- Contract labor
- Certain business travel and meals
- Cost of self-employed health insurance

If there are more people to include, please make a copy of pages 4 and 5 of 9. Complete and attach additional pages to this application as applicable. If not applicable, skip to page 6 of 9.(Step 3: Household Relationships)

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STEP 3: Household Relationships

There are 6 Household Member sections available for applicants to identify individual relationships to each other. Write the names and relationships of each household member to all individuals included on this application. Identify how each member is related to each other by using the following relationships listed below:

| | | |
|---|--|--|
| -Spouse -Unmarried Partner or Domestic Partnership -Parent (including step) -Child (including step) -Sibling (including step) | -Grandparent -Grandchild -Uncle Aunt -niece/nephew (including step) -Cousin -Under Primary Care | -Foster Parent -Foster Child -Not related -Other Related (i.e. in law living in home) |
|---|--|--|

Household Member PERSON 1 has been prepopulated to SELF.

In addition each household member is asked if they are the primary responsibility of a child(ren) under the age of 19. This question helps identify additional information for medical coverage.

If there are more than six (6) people in the home, a copy of Page 6 of 9 will need to be made and attached to this application.

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STEP 4 American Indian or Alaska Native (AI/AN) family member(s)

If anyone in your family is American Indian or Alaskan Native, mark “Yes” complete Appendix B: American Indian or Alaskan Native Family Member (AI/AN), and submit it with your application. There are special protections available for members of federally recognized tribes.

STEP 5 Your Family’s Health Coverage

Answer all questions as applicable for anyone who needs health coverage.

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STEP 6 Read & sign this application.

Read the statements on these pages, sign your name and write today’s date. By signing, you’re agreeing that the information you provided is true and correct.

If an authorized representative helped you to fill out this application, they can sign the form for you, but they’ll need to complete Appendix C: Assistance with Completing this Application, and submit it with your application.

You (PERSON 1 on the application) must sign Appendix C to allow the authorized representative to sign this application, get official information about this application, and act for you on all future matters related to this application.

If anyone on this application is eligible for Medicaid

The contact person or the authorized representative agrees to allow the Department of Human Services to pursue payments from any third-parties which may include but not limited to other health insurance or legal settlements. In addition, the Department of Human Services may pursue medical support from an absent parent, unless cooperating with medical support will harm him/herself or their children. He/she can tell Medicaid and they may not have to cooperate.

The contact person or authorized representative also agrees to cooperate with the Department of Human Services, Federal Quality control reviewers or auditors if their case is selected for a review.

APPENDIX A: Health Coverage from Jobs

If anyone in your family has an offer of health coverage from a job, including through a parent or spouse, provide information on the offer of coverage, regardless of whether the person is currently enrolled.

A copy must be attached for each job that offers coverage.

Tell us about the job that offers coverage.

The Employer Coverage Tool must be taken to the employer who offers coverage to help complete the questions. Appendix A only needs to be submitted with the application that is sent in.

EMPLOYER COVERAGE TOOL

Completion of the Employer Coverage Tool will help answer questions in Appendix A about any employer health coverage that the individual is eligible for (even if it's from other person's job, like a parent or spouse). The information in the numbered boxes matches the boxes on Appendix A. One tool must be completed for each employer that offers health coverage.

APPENDIX B

American Indian or Alaska Native Family Member (AI/AN)

Completion of Appendix B is only required if the individual or a family member are American Indian or Alaska Native. You'll be asked about the person's tribe membership, income and other information. Appendix B must be submitted with the Application for Health Coverage & Help Paying Costs.

Tell us about your American Indian or Alaska Native family member(s).

American Indians and Alaska Natives can get services from the Indian Health Services, tribal health programs, or urban Indian health programs. They also may not have to pay cost sharing and may get special monthly enrollment periods. Answer the following questions to make sure your family gets the most help possible.

NOTE: If you have more people to include, make a copy of this page and attach.

APPENDIX C: Assistance with Completing this Application

You can choose an authorized representative:

Someone who you choose to act on your behalf with the Marketplace, like a family member or other trusted person. Some authorized representative may have legal authority to act on your behalf.

Authorized Representative

If an authorized representative is designated, they agree to maintain the confidentiality of information provided to the applicant(s) by the State of Hawaii Department of Human Services. By signing and completing information requested below, the authorized representative also agrees to adhere to the regulations relevant to the State and Federal Laws covering conflicts of interest and confidentiality of information.

Certified application counselors, navigators, in-person assistance counselors, and other assisters:

These are professional individuals or organizations that are trained to help consumers looking for

health coverage options through the Marketplace, including help with completing this application. Services are free to consumers. You can ask to see certification showing they're authorized to perform this work. They can help you complete this section. The ID number is the navigator's identification number. This is a unique alphanumeric ID (13 letters and numbers) given to each navigator.

Agents and brokers:

Agents and brokers can help you apply for help paying for coverage and enroll in a Qualified Health Plan (QHP) through the Marketplace. They can make specific recommendations about which plan you should enroll in. They're also licensed and regulated by states and typically get payments or commissions from health insurance companies when they enroll consumers. They can help you complete this section.

List both ID numbers for agents and brokers:

FFM User ID: A unique ID that the agent broker creates when registering with the Marketplace.

National Producer Number (NPN): A unique number (up to 10 digits) that's assigned to each licensed agent or broker. A NPN can be easily located by going to the National Insurance Producer Registry's website at www.nipr.com.

Use this list below to answer questions about eligible immigration status.

Are you or a person(s) in your household a:

- Lawful permanent resident (LPR/Green Card holder)
- Asylee
- Refugee
- Cuban/Haitian entrant
- Paroled into the U.S.
- Conditional entrant granted before 1980
- Battered spouse, child, or parent
- Victim of trafficking and his or her spouse, child, sibling, or parent
- Individual granted Withholding of Deportation or Withholding of Removal under the immigration laws or under the Convention against torture (CAT)
- Individual with non-immigrant status (including worker visas, student visas, and citizens of Micronesia, the Marshall Islands and Palau)
- Individual with Temporary Protected Status (TPS)
- Individual with Deferred Enforced Departure (DED)
- Individual with Deferred Action Status (Deferred Action for Childhood Arrivals (DACA) isn't an eligible immigration status for applying for health coverage.)

OR Applicant for:

- Special Immigrant Juvenile Status
- Adjustment to LPR Status with an approved visa petition
- Victim of trafficking visa
- Asylum who has either been granted employment authorization OR is under 14 and has had an application for asylum pending for at least 180 days
- Withholding of Deportation or Withholding of Removal, under the immigration laws or under the Convention against Torture (CAT) who has either been granted employment authorization, OR is under 14 and has had an application for withholding of deportation or withholding of removal under the immigration laws or under the CAT pending for at least 180 days.

OR Certain individual(s) with employment authorization document(s):

Registry applicants

- Order of supervision
- Application for Cancellation of Removal or Suspension of Deportation
- Application for Legalization under 1986 Immigration Reform and Control Act (IRCA)
- Applicant for Temporary Protected Status (TPS)
- Legalization under the LIFE Act

OR

-Lawful temporary resident

- Granted an administrative stay of removal by the Department of Homeland Security (DHS)**
- Member of a federally recognized Indian tribe or American Indian born in Canada**
- Resident of American Samoa**

Immigration Status and Document Types:

If you're an eligible non-citizen applying for health coverage, list your immigration document. See the list below for some common document types. If the document you have isn't listed, you can still write its name. If you are not sure or you have an eligible status but no document, call the Federal Health Insurance Marketplace at 1-800-318-2596 for help.

| IF YOU HAVE: | LIST THE FOLLOWING INFORMATION FOR THE DOCUMENT ID |
|---|--|
| Permanent Resident Card, "Green Card" (I-551) | • Alien registration number • Cardnumber |
| Reentry Permit (I-327) | • Alien registration number |
| Refugee Travel Document (I-571) | • Alien registration number |
| Employment Authorization Card (I-766) | • Alien registration number • Expiration date • Cardnumber • Category code |
| Machine Readable Immigrant Visa (with temporary I-551 language) | • Alien registration number • Passport number |
| Temporary I-551 Stamp (on passport or 1-94/1-94A) | • Alien registration number |
| Arrival/Departure Record (I-94/I-94A) | • I-94 number |
| Arrival/Departure Record in foreign passport (I-94) | • I-94 number • Expiration date • Passport number • Country of issuance |
| Foreign passport | • Passport number • Country of issuance • Expiration date |
| Certificate of Eligibility for Nonimmigrant Student Status (I-20) | • SEVIS ID |
| Certificate of Eligibility for Exchange Visitor Status (DS2019) | • SEVIS ID |
| Notice of Action (I-797) | • Alien registration number or an I-94 number |
| Other | • Alien registration number or an I-94 number • Description of the type or name of the document |

You can also list these documents or statuses:

- Document indicating a member of a federally recognized tribe or American Indian born in Canada.
(Note: This is considered an eligible immigration status for Medicaid, but not for a Qualified Health Plan (QHP).)
- Office of Refugee Resettlement (ORR) eligibility letter (if under 18)
- Document indicating withholding of removal
- Administrative order staying removal issued by the Department of Homeland Security (DHS)
- Certification from U.S. Department of Health and Human Services (HHS) Office of Refugee Resettlement (ORR)
- Cuban/Haitian entrant
- Resident of American Samoa

FILING/DISTRIBUTION INSTRUCTIONS:

The DHS 1100 may be submitted to the Department by any of the following methods: via the Department's designated internet web site(s), by telephone, via the United States Postal Service, In Person or through other commonly available electronic means.