

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
<input type="checkbox"/>	<input type="checkbox"/>	Child Support		\$
<input type="checkbox"/>	<input type="checkbox"/>	Supplemental Security Income (SSI)		\$
<input type="checkbox"/>	<input type="checkbox"/>	Worker's Compensation		\$
<input type="checkbox"/>	<input type="checkbox"/>	Veterans Administration Income (VA)		\$
<input type="checkbox"/>	<input type="checkbox"/>	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
<input type="checkbox"/>	<input type="checkbox"/>	Checking Accounts (List all)			\$
<input type="checkbox"/>	<input type="checkbox"/>	Savings Accounts (List all)			\$
<input type="checkbox"/>	<input type="checkbox"/>	Cash			\$
<input type="checkbox"/>	<input type="checkbox"/>	Income Tax Refunds			\$
<input type="checkbox"/>	<input type="checkbox"/>	Stocks and Bonds			\$
<input type="checkbox"/>	<input type="checkbox"/>	Money Market Accounts, CDs, and Time Certificates			\$
<input type="checkbox"/>	<input type="checkbox"/>	IRA, Keogh, and Deferred Compensation			\$
<input type="checkbox"/>	<input type="checkbox"/>	Burial Plans: Total No. ____			\$
<input type="checkbox"/>	<input type="checkbox"/>	Burial Plots: Total No. ____			\$
<input type="checkbox"/>	<input type="checkbox"/>	Life Insurance (Surrender Cash Value)			\$
<input type="checkbox"/>	<input type="checkbox"/>	Family or Individual Trust or Trust Funds			\$
<input type="checkbox"/>	<input type="checkbox"/>	Business Equity (Self-Employed)			\$
<input type="checkbox"/>	<input type="checkbox"/>	Boats and Trailers			\$
<input type="checkbox"/>	<input type="checkbox"/>	Jewelry, Diamonds, Gold, Silver, Etc.			\$
<input type="checkbox"/>	<input type="checkbox"/>	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.

Certification and Authorization

The individual who signs this form should be listed as the Applicant/Beneficiary or Authorized Representative who had originally signed the application. If the individual signing this form is a different, he/she will supersede the individual who had originally signed the original application.

Applicant/Beneficiary (Authorized Representative as appropriate) Certification and Authorization:

- I certify that I am the Applicant/Beneficiary/Authorized Representative and am signing this form under penalty of perjury under state or federal laws. I have provided true answers to all the questions to the best of my knowledge.
- I understand that I must tell the Department of Human Services if anything changes (and is different than) from what I wrote on the application or this supplemental form and can visit www.mybenefits.hawaii.gov or call toll free 1-800-316-8005 to report any changes.
- I understand that I am required to report any changes within 10 days from the time I learn of the change.
- I understand that a change in my (applicant/beneficiary) information could affect my Medicaid eligibility.
- I understand that this authorization will end if my application for Medicaid is denied or I am no longer eligible for Medicaid, or I/we revoke this authorization in a written statement.

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.

*I understand I/we must report resources, by signing, I/we authorize verification of any resources with financial institutions for the purpose of determining eligibility. Both the spouse's Social Security (SSN) and signature must be provided even if not applying. This authorization will end if my application for Medicaid is denied, or I am no longer eligible for Medicaid, or I/we revoke this authorization in a written statement to my local Department of Human Services. SEC 1137(a) of the Act.

*Applicant/Beneficiary/Authorized Representative Signature:		Date (mm/dd/yyyy)
*Additional Household Member(s) Signature(s):	Relationship to Applicant/Beneficiary	Date (mm/dd/yyyy)
	*SPOUSE	

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

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