INSTRUCTIONS (AGENCY USE ONLY)
DHS 1100B (Rev. 04/2021)

ADDITIONAL REQUIRED INFORMATION
FOR INDIVIDUALS APPLYING FOR COVERAGE ON THE BASIS OF AGE, BLINDNESS, DISABILITY OR REQUESTS FOR LONG-TERM CARE SERVICES (Supplement to Form DHS 1100) INSTRUCTIONS

PURPOSE:

In addition to form DHS 1100, "Application for Health Coverage & Help Paying Costs", the DHS 1100B, "Additional Required Information for Individuals Applying for Coverage on the Basis of Age, Blindness, Disability or Requests for Long-Term Care Services", shall be completed for requests for Aged, Blind, Disabled and/or Long-Term Care Services. The information on this supplemental form provides additional information to the DHS 1100.

Note: This form may also be used with a DHS 1179A "Change of Circumstance Report Form" or at redetermination with a Redetermination form (N-14/DHS 1100B-2).

GENERAL INSTRUCTIONS:

This form shall be completed by the Applicant/Beneficiary or Authorized Representative acting on their behalf in all Medicaid related matters and on-going communication with the Department. If there are additional household members, please use this same form to complete needed information. If additional space is needed to add the information, please attach responses with this submission.

Note: An Authorized Representative shall have completed a DHS 1121 "Designation or Revocation of an Authorized Representative" or DHS 1121A "Agreement to Act as an Authorized Representative" with appropriate supporting documentation. The Med-QUEST Division will contact the Authorized Representative if the required documentation is not on file.

SPECIFIC INSTRUCTIONS:

For Med-QUEST Division Eligibility Staff:

The DHS 1100B, "Supplemental Form for Individuals Applying for Coverage on the Basis of Age, Blindness or Disability and/or Requests for Long-Term Care Services", shall be given to an applicant/beneficiary/Authorized Representative:

a. Whose eligibility is determined on the basis of being aged (65 years or older), recipient of SSI or Medicare, blind or disabled;
b. Who is requesting LTC services, except Nursing Facility if in an Adult Group; or
c. Whose application indicated that he/she is blind or disabled and is not eligible to participate in a MAGI group at application, redetermination or change of circumstance.

For Applicant/Beneficiary, Authorized Representative or responsible adult:

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

A. Complete this section for the individual who is requesting services.

If applicant/beneficiary is married, complete the spouse information even if spouse is not applying. The Social Security Number and signature of the spouse is **required** to determine eligibility of the individual applying for medical assistance. HAR §17-1724.1-9, §17-1725.1-10(c)

B.1. Check Yes or No for every type of income listed that the household (HH) receives. If YES is checked, list the name of the individual receiving the income and the amount received monthly.

C.1. Check Yes or No for every type of asset listed that the HH has. If YES is checked, list the owner's name, bank or company name and equity dollar value.

D.1. Check Yes or No if the applicant, their spouse or dependent(s) need help with any unpaid medical bills in the past 3 months? If Yes is selected, please fill in the name of the person with the bill, name of provider and service dates.
E. Check Yes or No to each question in this section. If Yes is selected, provide the requested information.
F. Check Yes or No to each question in this section. If Yes is selected, provide the requested information.
G. Check Yes or No to each question in this section. If Yes is selected, provide the requested information.

APPLICANT/BENEFICIARY/AUTHORIZED REPRESENTATIVE CERTIFICATION and AUTHORIZATION:
The individual who is signing this form certifies that they:

- Signed the application;
- Was designated by Person 1 on the application that they are the Authorized Representative; or
- Is the newly designated Authorized Representative; and has completed Appendix A, and
- All the information provided on this certification form is true and to the best of their knowledge and they understand that if they intentionally make false statements on this form, they may be prosecuted under Hawaii Revised Statutes §710-1063.
- They give permission to the State of Hawaii to check their statement under SSA VII, SEC 7001(d) of P.L. 110-252. It is mandatory that the applicant sign and provide their Social Security Number (SSN).
- They have read and understand the list of rights and responsibilities on the last page that they may keep for their information.

ADDITIONAL HOUSEHOLD MEMBERS CERTIFICATION AND AUTHORIZATION:
The individual who is signing this form certifies that they:

- Signed this form;
- All the information provided on this certification form is true and to the best of their knowledge and they understand that if they intentionally make false statements on this form, they may be prosecuted under Hawaii Revised Statutes §710-1063.
- They give permission to the State of Hawaii to check their statement under the requirements of SSA VII, SEC 7001(d) of P.L. 110-252. It is mandatory that the additional household member (i.e. spouse) sign and provide their Social Security Number (SSN) under §1940 of the Social Security Act.
- They have read and understand the list of rights and responsibilities on the last page that they may keep for their information.

Please return this completed form and a copy of the authorized representative document to the nearest Eligibility Branch Office (see page 5). You may also contact Customer Service at 808-524-3370 or your neighbor islands 1-800-316-8005, (TTY/TDD 711) for additional information.

FILING/DISTRIBUTION INSTRUCTIONS:

1. EB shall document 1100B information to the individual and household in appropriate KOLEA case and process individual eligibility for LTC services.

2. EB shall scan DHS 1100B form into the appropriate KOLEA case file.