Clear Form

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 (SSN *Mandatory even if not applying)
   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.

### 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

☐ **OAHU SECTION-HONOLULU**
801 Dillingham Blvd., 3rd Floor Honolulu, HI 96817-4582
Mailing: P.O. Box 3490 Honolulu, HI 96811-3490

☐ **OAHU SECTION-KAPOLEI**-Kakuhihewa State Bldg.
601 Kamokila Blvd., Room 415 Kapolei, HI 96707-2021
Mailing: P.O. Box 29920 Honolulu, HI 96820-2320

☐ **EAST HAWAII SECTION**
1404 Kilauea Ave. Hilo, HI 96720-4670

☐ **WEST HAWAII SECTION**-Lanihau Professional Center
75-5591 Palani Rd., Ste., 3004 Kailua-Kona, HI 96740-3633

☐ **KAUAI SECTION**-Dynasty Court
4473 Pahee St., Suite A Lihue, HI 96766-2037

☐ **MAUI SECTION**-Millyard Plaza
210 Imi Kala St. Ste., 101 Wailuku, HI 96793-1274

☐ **MOLOKAI UNIT**-State Civic Center
65 Makaena Place Rm. 110 Kaunakakai HI 96748-0169 Mailing: P.O. Box 1619 Kaunakakai, HI 96748-1619

☐ **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 _____<br>(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) |