STATE OF HAWAII
Department of Human Services

Med-QUEST Division

CWS/MQD COMMUNICATION FORM (FOSTER CARE)

Please Print or Type ☐ New ☐ Change ☐ Verification of Previous CWS Assistance
CWS comments: (If "Change" selected, write what was changed here)

SECTION 1 WORKER INFORMATION (To be completed by CWS SW/HSP or MQD)

1. Receiving Division: TO: ☐ MQD ☐ SSD	2. Section/Unit	3. Receiving MQD/SSD Worker Name	4. Effective Date	5. Date faxed/sent
6. Sending Division: FROM: ☐ MQD ☐ SSD	7. Unit No.	8. Sending Worker Name	9. Phone No.	10. Fax No.
11. Unit Address		12. Unit City/State/Zip	13. Supervisor Name	14. Supervisor Phone No.

SECTION 2 CHILD INFORMATION

15. Child's Last Name	16. Child's First Name	17. Middle Name.	18. Suffix	19. Gender

20. DOB	21. SSN	22. ICPC or ICAMA (attach ICAMA 7.01 form) ☐ Yes ☐ No	23. IV-E Status ☐ IV-E ☐ Non-IV-E ☐ Pending Effective date: _____	24. Placement ☐ Hawaii ☐ Out of State
25. CWS Case No.	26. KOLEA Client ID			24a. Placement Type ☐ Adoption ☐ Foster Care

27. Pregnant? ☐ Yes ☐ No	28. E.D.D.	29. No. of Babies	30. Retro Coverage? (up to 3 months prior to MQD app. date) ☐ Yes ☐ No Date(s): _____	31. Permanent Disability? ☐ Blind ☐ Disabled	32. Disability Determination ☐ SSI/SSDI Date ____ ☐ ADRC (Attach form)

33. Name of Medical Insurance	34. Information on file: ☐ Photo ☐ U.S. Birth Certificate ☐ Document Type: _____ ☐ Lawfully Present non-citizen ☐ Qualified non-citizen ID No.: _____
35. Foster Parent(s) Name(s)	36. Relationship to Child

FAMILY INFORMATION

37. Biological Mother's Last Name	38. First Name	39. M.I.	40. KOLEA Client ID	41. SSN	42. DOB
43. Biological Father's Last Name	44. First Name	45. M.I.	46. KOLEA Client ID	47. SSN	48. DOB

SECTION 3 PLAN SELECTION

49. Requested Plan Name

SECTION 4 CHANGES IN KINSHIP/GUARDIANSHIP/FOSTER CARE/ADOPTION SUBSIDY STATUS

50. Reason for Change of medical assistance: ☐ Aging Out ☐ Voluntary FC to Age 21 ☐ Kinship/Guardianship/Subsidized Adoption when they turned age 18 or older. ☐ Other Reason:_____	51. Reason for Termination of medical assistance: ☐ Returned to legally responsible family/Added to family medical case ☐ Kinship/Guardianship/Subsidized Adoption when they turned age 18 or older. ☐ Other Reason:_____

52. Parent/Legal Representative or Contact Name	53. Relationship	54. KOLEA Client ID
55. Child's Residence Address	56. Child's Mailing Address (if different)	

57. KOLEA Case No. _ _ _ _ _ _ _ _ - 01	58. Case Name	59. Date Case Opened

SECTION 5 VERIFICATION OF PREVIOUS CWS ASSISTANCE

60. Previous beneficiary of:
☐ Foster Care Aging Out
Age when terminated: _____
☐ KOLEA ID: _____
☐ Kinship/Guardianship/Subsidized Adoption –
Age when approved : _____
Age when terminated: _____

61. Verified by: (CWS Worker Name)	62. Title	63. Phone No.