INSTRUCTIONS
DHS 1106 (Rev. 10/2020)

CWS/MQD COMMUNICATION FORM (FOSTER CARE)

PURPOSE:

The DHS 1106, CWS/MQD Communication (Foster Care) form is a communication tool between the Child Welfare Services (CWS) Division and the Med-QUEST Division (MQD). This form is used to communicate information about all foster care cases, including new cases and changes in kinship/guardianship/adoption subsidy status. It is also used to verify previous CWS assistance for individuals applying for assistance as a former foster care child.

GENERAL INSTRUCTIONS:

Top of Form: New, Change, Verification of Previous CWS Assistance: Check the appropriate box for the type of submission. Note: Check only one box per form.

For all **new** foster care placements (even if individual is known to KOLEA in another non- foster care case), check the "New" box. CWS worker will need to complete all of Sections 1 and 2. In addition, if a Non-Title IV-E individual is unknown to KOLEA or known in an inactive case, a DHS 1100 must be completed.

Note: If "New" is selected on this form, this action is considered as "Application for Medical" on the SSD portal.

For any **changes** to the foster child's information, check the "Change" box. The CWS worker will also need to add comments regarding what areas on the form were changed and complete Section 1-4 as applicable.

For **verification** of previous CWS assistance, check the "Verification of Previous CWS Assistance" box and complete Section 5.

SPECIFIC INSTRUCTIONS:

SECTION 1: WORKER INFORMATION (to be completed by CWS SW/HSP/MQD as appropriate)

1. ***Receiving Division***: Check the appropriate box to identify the DHS division receiving the form.

2. ***Section/Unit***: Enter the section/unit numbers of the division that is receiving and processing the information.

3. ***Receiving MQD/SSD Worker Name***: If known, enter the MQD/SSD worker name. This will help to ensure the form is sent to the appropriate worker for processing.

4. ***Effective Date***: For CWS, enter the date of placement, change or termination. For MQD, enter the date that the DHS 1106 was received. The Effective Date for medical is the date that the DHS 1106 is received, and date stamped at the MQD office.

Examples:

a. MQD receives a DHS 1106 via paper with a received date stamped of 05/14/18. The "The Effective Date" is 05/14/18.
b. MQD receives a DHS 1106 via paper that requires a DHS 1100. The date on the DHS 1100 is 05/15/18 but the date of the DHS 1106 is 05/14/18. The "Effective Date" is 05/14/18.

5. ***Date faxed/sent***: Enter the date the form is faxed or sent via interoffice mail to the appropriate division.

6. ***Sending Division:*** Check the appropriate box to identify the DHS division that is sending the form.

7. ***Unit No***: For CWS, identify the Unit that is responsible for the child, for MQD; identify the unit making the request.

8. ***Sending Worker Name***: Enter the CWS worker name who should be contacted for additional information on the child or the name of the MQD EW making the request.

9. ***Phone No***: Enter the phone number of CWS/MQD Worker as applicable.

10. ***Fax No***: Enter the fax number of CWS/MQD Worker as applicable.

11. ***Unit Address***: Enter the address for the CWS unit that should be used to receive mail for the child (e.g., annual redetermination, plan change form, etc.) or the requesting MQD office as applicable.

12. ***Unit City/State/Zip***: Enter the city, state and zip code associated with the CWS/MQD unit address as applicable.

13. ***Supervisor Name***: Enter the CWS/MQD Supervisor's name of the CWS/MQD worker as applicable.

14. ***Supervisor Phone No.***: Enter the CWS/MQD Supervisor phone number as applicable.

SECTION 2: CHILD INFORMATION

Note: If there are multiple children (siblings) who are in the same placement or if in different placements, use a separate form for each child.

15. ***Child's Last Name***: Enter the child's legal last name.

16. ***Child's First Name***: Enter the child's legal first name.

17. ***Child's Middle Name***: Enter the child's middle name.

18. ***Suffix:*** Complete as appropriate.

19. ***Gender***: Enter the child's gender. This is child's gender at birth and not the child's preference.

20. ***Date of Birth***: Enter the child's birth date. This information is essential to processing the applicant/beneficiary information for medical coverage appropriately. MQD will need this information to be added by the CWS worker if available.

21. ***SSN***: Enter the child's social security number (last 4 digits). Note: For newborns, a social security number will be required at age 1.

22. ***ICPC or ICAMA***: Check Yes or No. If yes, attach documents below as applicable.
    a. Interstate Compact on the Placement of Children (ICPC) attach referral and/or appropriate documentation.
    b. Interstate Compact on Adoption and Medical Assistance (ICAMA) attach ICAMA 7.01.

23. ***IV-E Status***: Identify whether the child is receiving benefits under Title IV-E or not. Children living in Hawaii receiving Title IV-E foster care payments receive medical assistance "automatically" and an application is NOT required. If Title IV-E, document effective date in area provided. If the child is not receiving benefits under Title IV-E, a medical application is required and should be attached to the form.

24. ***Placement***: Indicate whether the child is placed in or out of Hawaii.

24a. ***Placement Type***: Indicate whether the child is placed in Adoption or Foster Care.

25. ***CWS Case No***: Enter CWS case number for the child. (If child has a sibling, list case number of siblings.)

26. ***KOLEA Client ID***: Enter the child's KOLEA ID.

27. ***Pregnant***: Identify whether the child is pregnant.

28. ***Est. Del. Date***: If the child is pregnant, identify the estimated delivery date.

29. ***No. of Babies***: If the child is pregnant, identify the number of babies expected during this pregnancy.

30. ***Retro Coverage:*** Check Yes or No and list date(s) individual received medical services.
    Note: Retro-coverage is limited to 3 months prior to the date the application is submitted. For example, application submitted on Sept 1, 2020. Retroactive coverage can only go back to June 1, 2020.

31. ***Permanent Disability?*** Identify whether the child meets criteria for being blind or having a permanent disability.

32. ***Disability Determination****:* If the child is disabled (SSI/SSDI Date selected) enter date of disability or onset. If an ADRC determination was made, attach DHS 1180 form.

33. ***Name of Medical Insurance:*** Write name of medical insurance if known.

34. ***Information on File***: Attach document if available. Check the appropriate boxes to identify.
    a. If there is a photo or U.S. birth certificate on file. The CWS file should contain a photo of the child as proof of identity. MQD will not request additional documentation if in the CWS file.
    b. If the child is lawfully present or has qualified non-citizen status enter document type and ID number.

35. ***Foster Parent(s) Name(s)***: Enter the foster parent(s) name(s) of the child.

36. ***Relationship to Child***: Enter the relationship (grandparent, aunt, uncle, etc.) if there is a relationship to the child.

SECTION 2: FAMILY INFORMATION

37. ***Biological Mother's Last Name***: Enter the biological mother's legal last name.

38. ***First Name***: Enter the biological mother's legal first name.

39. ***Middle Initial***: Enter the biological mother's middle initial(s).

40. ***KOLEA Client ID***: Enter the biological mother's KOLEA ID.

41. ***SSN***: Enter the biological mother's social security number (last 4 digits).

42. ***Date of Birth***: Enter the biological father's birth date.

43. ***Biological Father Last Name***: Enter the biological father's legal last name.

44. ***First Name***: Enter the biological father's legal first name.

45. ***Middle Initial***: Enter the biological father's middle initial(s).

46. ***KOLEA Client ID***: Enter the biological father's KOLEA ID.

47. ***SSN***: Enter the biological father's social security number (last 4 digits).

48. ***Date of Birth***: Enter the biological father's birth date.

SECTION 3: PLAN SELECTION

This information is used to select a new or change a plan for the child. If the child is currently enrolled in a Medicaid plan, the plan enrollment continues until a new selection is made.

49. ***Requested Plan Name***: Enter the name of the new plan that is desired for the child.

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

50. ***Reason for Change of Medical assistance***: Check the appropriate box for change type. If child has aged out, voluntary foster care to age 21, Kinship/Guardianship/Subsidized Adoption when they turned age 18 or older, or Other Reason. If Other Reason is selected, the individual completing this section must put a reason in space provided.

    The information will be used to determine whether the child qualifies for placement in the "former foster care" eligibility group.

    (Note: Effective Date should be entered as date of change. If applicable, attach documents.)

51. ***Reason for Termination of Medical assistance***: Check the appropriate box for termination type. If child has returned to their legally responsible family or added to family medical case, or Kinship/Guardianship/Subsidized Adoption when they turned age 18 or older, or Other Reason. If Other Reason is selected, the individual completing this section must put a reason in space provided.

52. ***Parent/Legal Representative or Contact Name***: Enter name of parent/legal representative or contact name if the child is being terminated from CWS as either kinship/guardianship/adoption or being returned to the family. If the child is aging out and considered emancipated, then leave blank.

53. ***Relationship***: Enter relationship of child to the parent/legal representative of contact. Complete only if question 41 is completed.

54. ***KOLEA Client I.D.***: Enter the individual's KOLEA ID. It is possible that a child has two separate KOLEA IDs. If this is the case, enter both.

55. ***Child's Residence Address***: Provide the address of the child. Complete for all reasons for termination including aging out.

56. ***Child's Mailing Address (if different)***: Provide the mailing address if different from the residence address.

57. ***KOLEA Case Number***: Enter KOLEA Case Number.

58. ***Case Name***: Enter the full name of the Primary Individual on Case.

59. ***Date Case Opened:*** Enter the date that the case was opened.

SECTION 5: VERIFICATION OF PREVIOUS CWS ASSISTANCE

60. ***Previous beneficiary of:*** Enter the type of assistance the individual previously received. For Foster Care, enter date CWS benefits were terminated. For Kinship/Guardianship and Subsidized Adoption, enter age of individual when approved, and age when benefits were terminated.

61. ***Verified by:*** Enter name of CWS worker verifying the information in this section. If CWS contact information is not on the form, EW to contact CWS worker for information.

62. ***Title:*** Enter CWS worker job title.

63. ***Phone No.:*** Enter the phone number of the CWS worker.

FILING/DISTRIBUTION:

1. CWS to send original to MQD-EW.
2. CWS to file copy.
3. EW to scan to KOLEA and file original in client records.