DEATH PAYMENTS PROGRAM APPLICATION

Note: A certified death certificate or death confirmation document from agencies with authority to confirm the death is needed and must be submitted within 60 days from the date of death. If the document is available at the time you turn in this application, please attach.

I. Decedent's information:

Decedent's Name (Last, First, M.I):		Sex:
Social Security No.:	Veteran – VA File Number:	Date of Birth:
Was the individual eligible or receiving medical and/or financial services at time of death? ☐ Yes ☐ No		Date of Death:
Body Location (specify: e.g. hospital, nursing home, mortuary or medical examiner)		

II. Interested Party/Applicant's information:

Interested Party/Applicant's Name (Last, First, M.I):	Relationship/Responsibility to Decedent:
Home/Cell Phone:	Work Phone:
Interested Party/Applicant's Mailing Address:	

III. Are any full funeral benefits available to the decedent such as but not limited to pre-paid funeral or burial plans, insurance plans, associations, and clubs? (Full funeral benefits mean funeral and/or burial services that provide a complete and dignified disposal of the decedent.)

☐ Yes ☐ No

IV. Has anyone received or expect to receive, the lump-sum death payment benefit from Social Security for the decedent?

☐ Yes ☐ No

V. I understand that by signing below:

1. **I am responsible for coordinating transport of the decendents body to the appropriate burial place and if the decedents body is not transported to the appropriate burial place, Medicaid can pursue overpayment or collection.**
2. **The Department of Human Services may recover for payments made by the Death Payments Program from the Veteran's Administration (VA) or the estate of the decedent.**
3. **I certify the information I have provided on this application is true to the best of my knowledge. If I intentionally make false statements on this application, I may be prosecuted under Hawaii Revised Statutes §346-43.5 or other criminal laws.**
4. **I further certify that the Death Payments Program payment shall be made to me and sent to my address as listed under Item II above.**

Interested Party/Applicant's Signature Date

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VI. Disposition: Application is: ______ Approved ______ Denied ______ Discontinued

Explanation/reason for disposition:

Printed Name of Eligibility Worker Authorized Eligibility Worker's Signature Date