OFFICIAL USE ONLY
Case Name:
Case No.:
Received Date:

CHANGE OF CIRCUMSTANCE REPORT FORM

You must report any changes to your household (if anyone moves in or out of your household, if anyone gets married, becomes pregnant, or gives birth to a child), a change in address, income or employment status **within 15 days of the event.** If this report does not provide enough room to document a change, attach a sheet of paper with the additional information. You may also report changes online at www.mybenefits.hawaii.gov, by telephone or in person. Failure to report changes may result in benefits being denied, terminated or stopped. Auth.: H.A.R. §17-1712.1-4

Primary Individual Name: (Last, First, MI)	Date of Birth: (mm/dd/yyyy)	Client ID or SSN:
Current Address (Street, City, State, Zip code):		Phone: ( )
Check one if you are completing on behalf of the Medicaid beneficiary		**Must Check one:**
☐ Authorized Representative (DHS1121)	☐ Legal Guardian, POA or Conservator (Legal document)	☐ **ON FILE or** ☐ **ATTACHED**
Name: (Last, First, MI)		

Requests for change of circumstance by an Authorized Representative, Legal Guardian, Power of Attorney or Conservator on behalf of the Medicaid beneficiary requires proof of authorization. If the Department does not have a signed authorization on file from the beneficiary, the request for a change of circumstance on the Medicaid beneficiary's behalf will not be processed until proof is received by the Department.

INTERPRETER REQUESTED: ☐ **YES** ☐ **NO** **LANGUAGE REQUESTED:**

☐ **SECTION 1 – TERMINATE MEDICAL ASSISTANCE CASE:** Effective Date: (mm/dd/yyyy)

Reason:

☐ **SECTION 2 - NAME CHANGE: (Attach copy of legal document)**

Reason for change: (complete section 5 if applicable)	☐ Marriage ☐ Divorce ☐ Adoption/Court Order ☐ Other-Specify:
From:	(Last, First, MI):
To:	(Last, First, MI):

☐ **SECTION 3: ADDRESS &/OR TELEPHONE CHANGE (This change will apply to ALL household members in your case, if this is incorrect, please specify in Section 8 who this change applies to.)**

	(Street No. & Name)	(City)	(State)	(Zip Code)
New Residence:				
	(Street No. & Name)	(City)	(State)	(Zip Code)
New Mailing:				
New Phone No.:	( )	Email Address:		

☐ **SECTION 4 - REPORT OR CHANGE OF PREGNANCY:**

Pregnant Woman Name (Last, First, MI)	Date of Birth: (mm/dd/yyyy)	Client ID (or SSN optional):
Number of Babies Expected:	Due Date: (mm/dd/yyyy)	End Date of Pregnancy: (mm/dd/yyyy)

☐ **SECTION 5 - REPORT OR CHANGE OF THIRD PARTY LIABILITY (TPL) COVERAGE: (Attach copy of insurance card if available)**

Name: (Last, First, MI)	Date of Birth: (mm/dd/yyyy)	Client ID (or SSN optional):
Health Plan Name:	Subscriber/Member No.:	
Type of Plan Coverage: (Check all that apply)	☐ Medical ☐ Dental ☐ Vision ☐ Drug ☐ Psych ☐ Other-Specify:	
Effective Date of TPL: (mm/dd/yyyy)	Termination Date: (mm/dd/yyyy)	
Do you receive Medicare coverage? ☐ YES ☐ NO	Medicare Number:	

If you need to ADD additional insurance, please make a copy of this sheet, complete and submit together.

CASE NAME: CASE NO.:

☐ SECTION 6 - CHANGE IN HOUSEHOLD MEMBERS:

☐ **ADD TO HOUSEHOLD** ☐ **CHANGE INFORMATION** ☐ **DELETE FROM HOUSEHOLD**
☐ Date of Death: ☐ Other:

Do you need medical assistance? ☐ **YES** ☐ **NO**

- The date this form is received by the Department will be the date considered for medical assistance redetermination.

If you received any medical services in the past ten (10) calendar days, you must complete & attach a DHS 1100-Application for Health Coverage. Medical assistance shall be considered for the ten (10) calendar days prior to the date the DHS 1100 application is received by the Department. A Social Security Number (SSN) is required if you are applying for medical assistance.

Name: **(Last, First, MI)**	**Date of Birth:** **(mm/dd/yyyy)**	**Client ID** **(or SSN optional):**
NEWBORN(S): **Mother's** Name (Last, First, MI)	Date of Birth: (mm/dd/yyyy)	Mother's Client ID (or SSN optional):
NEWBORN(S): **Father's** Name (Last, First, MI)	Date of Birth: (mm/dd/yyyy)	Father's Client ID (or SSN optional):

Gender: ☐ M ☐ F Citizenship Status: ☐ U.S. ☐ Alien Number: ☐ Other:

Relationship to the Primary Insured: **(check one)** ☐ Spouse of ☐ Civil Union of ☐Parent of ☐ Child of ☐ Sibling of ☐ Grandparent of ☐Sibling of ☐ Other

Claimed as a Tax Dependent: ☐ YES ☐ NO **Tax Filer Name:** (Last, First, MI)

Do you receive or need Long-Term Care services in a Nursing Home, Adult Foster home, In your own home, Assisted Living home or Retirement/Life Care Community?	☐ YES	☐ NO
Do you have a disability lasting more than 12 months?	☐ YES	☐ NO
Do you receive Social Security Supplemental Income (SSI)?	☐ YES	☐ NO

☐ SECTION 7 - REPORT OR CHANGE IN INCOME:

Name: (Last, First, MI) Date of Birth: (mm/dd/yyyy) Client ID (or SSN optional):

☐ **CURRENT INCOME**		☐ **ADD INCOME**	
☐ **No Change** Continue ☐ **Change** Effective Date: ______________________ ☐ **End** Effective Date:		Start Effective Date:	
Employer Name/Source of Income:		Employer Name/Source of Income:	
Income (before taxes) $	Average hours per week:	Income (before taxes) $	Average hours per week:
☐ Hourly ☐ Monthly ☐ Weekly ☐Twice a week	☐ Every 2 weeks	☐ Hourly ☐ Monthly ☐ Weekly ☐ Twice a week	☐ Every 2 weeks

If you need to ADD additional person(s) or income, please make a copy of this sheet, complete and submit together.

☐ SECTION 8 - OTHER CHANGES-Indicate below:

The Department may send you additional forms for additional information based on eligibility on a basis other than modified adjusted gross income (MAGI) and/or for long-term care. A change in information submitted by you could affect the eligibility for member(s) of your household. The Department of Human Services will obtain information to verify eligibility with electronic databases including but not limited to the Internal Revenue Service, Social Security Administration, Department of Homeland Security or a consumer reporting agency. If the information does not match, we may ask you to send us proof. **I certify the information that is provided on this Change of Circumstance Report form is true and to the best of my knowledge. If I intentionally make false statements on this form, I may be prosecuted under Hawaii Revised Statutes §710-1063. I give permission to the State of Hawaii to check my statements.**

Signature:		**Date:**
DHS/MQD USE ONLY	COC COMPLETED IN KOLEA BY:	COMPLETED DATE: