Return this form to:
State of Hawaii – Dept. of Human Services
Med-QUEST Division
P. O. Box 3490
Honolulu, HI 96811-3490

Month XX, 2024

Case Number: 00000000-01
Telephone Number: (808) XXX-XXXX

FIRST LAST
STREET HWY
APT ###
CITY, HI ZIP

RE: **MEDICAL ASSISTANCE ELIGIBILITY RENEWAL FORM – N14**

Aloha PI_FIRST PI_LAST,

This is your eligibility renewal form which is required annually. **Please review all of the information below, enter new or changed information into all sections and answer all questions on this form.**

DUE DATE: Return this form and any requested documents to us by <DUE DATE for Renewal Form>

Did you know you can now easily complete this form online?
Go to medical.mybenefits.hawaii.gov to complete your eligibility renewal today!

<<Add new N40 table with approved/ex parte members>>

Medical assistance coverage may be terminated for the following individuals if your renewal is not completed by the due date.

Dynamic Text (if we know that income is an issue): *"It appears that your income has changed. Please update your income below and provide documentation."*

Name	Documents
FIRST LAST SUFFIX	Proof of household's current monthly gross income-pay stubs, Social Security or other award letters, pension, employer statements, etc.

You can complete your renewal in any of the following ways:

- ***Complete your renewal online at medical.mybenefits.hawaii.gov***
- ***Call us to complete your renewal over the phone***
- ***Complete, sign, and return this form to us by mail, email or fax***
- ***Visit one of our offices to complete your renewal in person***

See the **Forms Instructions Section** at the end of this notice for details on how to submit your renewal form.

DUE DATE: Return this form and any requested documents to us by <DUE DATE for Renewal Form>

Section A Household Information:

Yes No

☐ ☐ **A1. Contact Information:** Did your name, address (residential and/or mailing), telephone number, or email address change?

Current Information	**Changed To**
Name (First, Middle, Last, Suffix): FIRST LAST	
Residential Address: #### STREET HWY, APT ### CITY, HI ZIP	
Home Phone: (808) XXX-XXXX	
Cell Phone:	
Work Phone:	
Email:	

Yes No

☐ ☐ **A2. Changes to Current Household:** Has there been a change in the members of your household or end Med-QUEST coverage for any household members?

The following household relationship section is filled with the relationships between the Primary and each member of the household. If any of the listed relationships are incorrect, strike them out and write in the correct relationship. If the relationship is blank, please write in the correct relationship type.
* Add any missing household members in the blank spaces provided

If there are no changes, please go to question A3

Name	Relationship to Primary	Changed to

Yes No

☐ ☐ **If there are changes to your household please use chart below to update information on members who have left the household or no longer need benefits.**

If you need to add a member, please fill out Appendix A.

HOUSEHOLD MEMBER REMOVED OR STOP BENEFITS			
Name (First, Middle, Last, Suffix)	**Reason (See example below)**	**Date removed**	**Stop Benefits**
			☐ Yes ☐ No
Examples of reasons for household member removal: *Moved Out; In Prison or Hawaii State Hospital; Divorced; Deceased; Nursing Home or Community Care Foster Family Home; Other Reason (please explain)*			

Yes No

☐ ☐ **A3. Tax filing Household:** Is the tax filing information listed below correct? If not please update table below.

Name (First, Middle, Last, Suffix)	Individual or Joint?
Do you claim any tax dependents? ☐ YES ☐ NO	Name of Spouse (First, Middle, Last, Suffix)
Name of tax dependents (First, Middle, Last, Suffix) :	
Are you being claimed as a dependent on someone else's taxes? ☐ YES ☐ NO	
If you are being claimed as a dependent name (First, Middle, Last, Suffix) of tax filer claiming you as a dependent:	

Yes No

☐ ☐ **A4. Household Income:** If the information we have below has changed, please attach copies of the changes. (For example, pay statements for the past three months.) If you are self-employed, please provide documentation of your self-employment income details.

Name (First, Middle, Last, Suffix)	Income Source	Monthly Gross Amount	Employer/ *Self - Employment	Start Date	End Date
	Other Exempt Income				
Changed To:					
	Social Security Benefits				
Changed To:					

* Please deduct your self-employment business expenses from the monthly income reported above.

Yes No

☐ ☐ **A5**. Is anyone in this household currently enrolled in health coverage other than Medicaid (QUEST Integration)?

Name (First, Middle, Last, Suffix)	Health Insurance Carrier/Plan	Policy Id	Start Date	End Date
PI_FIRST PI_LAST				
NAME ONE				
NAME TWO				
NAME THREE				
NAME FOUR				

These sections should be dynamic so we don't populate them if there are no HH Members over age 65 or disabled, etc.

Case Numbe

Section C

This section does not apply to your household. Please continue to next section.

Section D

This section does not apply to your household. Please continue to next section.

Section E

This section does not apply to your household. Please continue to next section.

Section F

Section B

Yes No

☐ ☐ **SKIP SECTIONS C, D-IF NO HOUSEHOLD MEMBERS ARE:**

- 65 years old or older
- receiving Supplemental Security Income (SSI) Benefits and/or
- receiving benefits based on disability and/or
- receiving of Medicare A/B or both

B1. Do you have a member who is now age 65 or older, blind or disabled? This includes receiving Supplemental Security Income (SSI) Benefits, receiving benefits based on disability, or receiving Medicare Part A or B. If your information has changed, please update this information below.

Name (First, Middle, Last, Suffix)	Blind/Disabled	Age 65 or older	Receiving SSI	Medicare
	☐	☐	☐	☐
	☐	☐	☐	☐
	☐	☐	☐	☐

Section C

Yes No

☐ ☐ **C1**.Did anyone's assets (bank/financial institution accounts, home, 401K, stocks, etc.) change? Please make any changes below. * Balance as of the 1st of the current month

Name (First, Middle, Last, Suffix)	Resource Type/Financial Institution	Last Reported Value	Enter Balance as of the first of this month
	Checking or Saving Account		

Section D

Yes No

☐ ☐ **D1**. Do you or anyone in your household own any real property?

Owner's Name (First, Middle, Last, Suffix)	Property Address	Current Value

Yes No

☐ ☐ **D2**. Do you and/or your spouse own any annuity?

Owner's Name (First, Middle, Last, Suffix)	Issuance Date	Name and Address of Annuity Company

Yes No

☐ ☐ **D3**. Do you or anyone in your household owe a loan, mortgage or promissory note?

Owner's Name (First, Middle, Last, Suffix)	Transaction Date	Original Amount	Balance Owed

Yes No

☐ ☐ **D4**. Do you or anyone in your household purchase life estate interest in a property of another?

Owner's Name (First, Middle, Last, Suffix)	Transaction Date	Address Of Property	Amount Paid

Yes No

☐ ☐ **D5**. Do you or anyone in your household pay an entrance fee to enter a Continuing Care Retirement Community (CCRC) or Life Care Community (LCC)?

Owner's Name (First, Middle, Last, Suffix)	Issuance Date	Name & Address of CCRC/LCC	Amount Paid

Section E Long-Term Care Services

Yes No

☐ ☐ **E1**. Does anyone in your household 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?

Name of Individual(s) (First, Middle, Last, Suffix): _____

Name of Individual(s) (First, Middle, Last, Suffix): _____

Yes No

☐ ☐ **E2**. Did you and/or your spouse sell, trade, or give away property or other assets--including money--within the past 60 months? Or, did you and/or your spouse make transfers into a trust within the past 60 months?

Name (First, Middle, Last, Suffix)	Type of Asset	Reason	Transfer Date	Value	Amount Received

Section F Other Changes

Yes No

☐ ☐ **F1**. Do you have other changes to report? *If reporting other changes, please provide supporting documentation.*

_____

_____

PLEASE SIGN BELOW AND RETURN FORM TO US by mail, email, fax or in person at our office.
REMINDER: You can also call us to complete your renewal over the phone.
See FORM INSTRUCTIONS SECTION for details

I certify the information that is provided on this recertification 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. By signing, I authorize verification of any eligibility requirements, to include resources with financial institutions. I give permission to the State of Hawaii to check my statements. I have read or had read to me the list of rights and responsibilities on the last page that I may keep for my information.

Primary Contact/Beneficiary/Authorized Representative Signature:	Date (mm/dd/yyyy)

Thank you for your time and we look forward to assisting you!

FORMS INSTRUCTIONS SECTION

PURPOSE:

The DHS 1100B-2 Medical Assistance Eligibility Renewal Form, shall be used as the paper version of the N-14 Renewal Notice. If in the event a N-14 Renewal Notice cannot be used, the DHS 1100B-2 can be used instead.

INSTRUCTIONS:

This form shall be completed by the Primary Contact or Authorized Representative.

For Primary Contact:

If more space is needed for your responses, please attach a separate sheet of paper to this renewal form. Section A.-F. select Yes or No check box and answer questions as appropriate.

PRIMARY CONTACT SIGNATURE:

The Primary Contact must sign this section and provide requested information. By signing they certify that the information provided on this recertification form is true and correct to the best of their knowledge and that they give permission to the State of Hawaii to check their resources as permitted under Hawaii Revised Statutes §710-1063.

Please return this completed form and a copy of the authorized representative document to address listed on page 1 of this form or to the Eligibility Branch Office near you (see below). You may also contact Customer Service at 1-800-316-8005, (TTY/TDD 711) to complete your renewal over the phone.

Statewide	**Med-QUEST Eligibility & Enrollment Service Centers** **1-800-316-8005 (Phone)** **711 TTY/TDD (Available to deaf, hearing, and speech impaired)** **1-800-576-5504 (Fax)** **MQDCustomerSupport@dhs.hawaii.gov (Email)** **P.O. Box 3490, Honolulu, HI 96811-3490 (Mailing)**
HAWAIʻI	**Hilo Service Center** 1404 Kilauea Avenue, Hilo, HI 96720 **Kona Service Center** Lanihau Professional Center, 75-5591 Palani Road, Suite 3004, Kailua-Kona, HI 96740
KAUAʻI	**Kauai Service Center** Dynasty Court, 4473 Pahee Street, Suite A, Lihue, HI 96766
MAUI	**Maui Service Center (Maui County)** Maui Millyard Plaza, 210 Imi Kala Street, Suite 101, Wailuku, HI 96793 Molokaʻi State Civic Center, 65 Makaena Street, Room 110, Kaunakakai, HI 96748 Lanaʻi 730 Lanaʻi Avenue, Lanaʻi City, HI 96763

OAHU	**Oahu Service Center**	
	Honolulu	1350 South King Street, Suite 200, Honolulu, HI 96814
	Kapolei	601 Kamokila Boulevard, Room 415, Kapolei, HI 96707
	Waipahu	94-275 Mokuola Street, Suite 301, Waipahu, HI 96797

APPENDIX A
ADD A HOUSEHOLD MEMBER

NEW HOUSEHOLD MEMBER: ***If you need to ADD more than one (1) new member, please make a copy of this page and the next or attach a separate sheet of paper and respond to the following questions for each household member added or contact Customer Service at 1-800-316-8005 (TTY: 711 or 1-800-603-1201) for additional assistance:***		
New Member Name (First, Middle, Last, Suffix)		
If new member is a newborn, please provide mother and father name below:		
Mother's Name (First, Middle, Last, Suffix):	Father's Name (First, Middle, Last, Suffix):	
Applying for Medical Coverage? ☐ **YES** ☐ **NO** Medical Services received within the past 90 days? ☐ **YES** ☐ **NO** If yes, date:		
Gender	Date Of Birth	**Social Security Number
***A Social Security number (SSN) **must be provided** for each individual (including children) **applying for Medical assistance**. We may contact your household if additional information is needed. Benefits may be delayed if requested information is not received. If help is needed to get an SSN or a replacement SSN card, call 1-800-772-1213 or visit socialsecurity.gov.* *TTY users should call 1-800-325-0778*		
Married? ☐ **YES** ☐ **NO**	If Yes, Name of Spouse (First, Middle, Last, Suffix):	
Gross monthly income (total income **before** taxes or other deductions):		
Plan to file a federal income tax return? ☐ **YES** ☐ **NO** Filing jointly with spouse? ☐ **YES** ☐ **NO**		
Will claim any tax dependents on their tax return? ☐ **YES** ☐ **NO**		
Write name(s) of tax dependents (First, Middle, Last, Suffix):		

Will be claimed as a tax dependent on someone's tax return? ☐ **YES** ☐ **NO**		
If yes, name of the tax filer (First, Middle, Last, Suffix):	*Relationship:	
Is the new member pregnant? ☐ **YES** ☐ **NO**	Expected Due Date:	How many expecting:
Are you a U.S. Citizen/National? ☐ **YES** ☐ **NO**		
If No, does the new member **have eligible immigration status**? ☐ **YES** ☐ **NO**		
Date of Entry _____ Alien or I-94 No. _____		
Immigration Document Type (i.e. I-551, Visa, etc.):	Status type	
Name (First, Middle, Last, Suffix) as it appears on your immigration doc.		
Passport No. other card no.		
SEVIS ID or Expiration Date (optional)	Category Code	
Is the new member claimed as a tax dependent on any of the household members taxes? ☐ **YES** ☐ **NO** If yes, please list the name of the household member that they are claimed as a tax dependent below.		

Examples of household relationships (including step where applicable) below:				
• Married	• Parent	• Child	• Sibling	• Under Primary Care
• Grandparent	• Uncle/Aunt	• Niece/Nephew	• Cousin	• Grandchild

• Foster Parent	• Foster Child	• Unmarried Partner or Domestic Partnership	• Not Related
• Other Related (please explain)			
How is the new member related to the Primary Contact on this Form? (*examples of relationship on previous pg.)			
If there are other members in this household, (living at the "current address" listed) please list who they are and how the new member is *related to them below:			
Current household member (First, Middle, Last, Suffix):		Relationship to new member (First, Middle, Last, Suffix):	
1.		1.	
2.		2.	
3.		3.	
4.		4.	
5.		5.	
6.		6.	
If there are more than (6) people in this household please make a copy of this page, complete and attach.			

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YOUR RIGHTS TO REQUEST AN ADMINSTRATIVE HEARING

WHAT IS AN ADMINISTRATIVE HEARING ("hearing")? A hearing is a fair review of the Department's action on your case and must be requested within 90 calendar days from the date of this notice. A hearing officer who was not involved in the Department's action will review all the facts of your case. If the hearing officer finds that the Department made a mistake, the Department will correct the action. HAR 17-602.1-3 to 4; 17-602.1-6; 17-602.1-24; 17-602.1-26; 17-602.1-28; 17-602.1-37; 17-1703.1-2 to 4; 17-1713.1-2

REASONS TO ASK FOR A HEARING:

- You do not agree with a decision that was made on your application or case.
- Your application was not processed timely: 30 days for a SNAP; 90 days for a medical assistance on the basis of a disability; 45 days for a financial assistance or other medical assistance application.

HAR 17-602.1-4; 17-602.1-24; 17-647-3; 17-647-7; 17-647-14; 17-1711.1-32

HOW DO I ASK FOR A HEARING? You can ask for a hearing in writing on the Department's form or any other paper. For SNAP and medical assistance only, you can also call or tell a worker that you want a hearing. When the Department receives your request, the Administrative Appeals Office will mail you information about your hearing.
HAR 17-602.1-6; 17-602.1-31; 17-1703.1-4

MY BENEFITS WILL BE STOPPED. CAN I CONTINUE TO RECEIVE BENEFITS WHILE MY HEARING IS PENDING? Yes, please read the notice for the deadline to ask for continued benefits. If the hearing decision is not in your favor, you must repay the benefits you were not entitled to receive. HAR 17-602.1-10; 17-602.1-12; 17-602.1-18; 17-602.1-34; 17-1703.1-5; 17-1703.1-17

HOW LONG DOES THE PROCESS TAKE? The process generally takes 60 days for SNAP or 90 days for other programs. For medical and SNAP hearings, you may ask for an expedited hearing process for extreme cases, such as when life or health are at serious risk. HAR 17-602.1-16; 17-602.1-27; 17-602-1-29; 17-1703.1-4; 17-1703.1-15 to 16.

DO I NEED A LAWYER? A lawyer is not needed. You must participate in the hearing unless you tell the Department, in writing, that an authorized representative will participate for you. An authorized representative can be a friend, relative, advocate, or another person. For free legal advice or representation, contact the Legal Aid Society of Hawaii at 808-536-4302 (Oahu) or 1-800-499-4302 (Neighbor Islands). HAR 17-602.1-5; 17-602.1-7; 17-602.1-25; 17-602.1-38; 17-1703.1-3

WHAT IF I NEED AN INTERPRETER OR OTHER ACCOMODATION? In your hearing request, you can ask for a free professional interpreter, larger print, sign language interpreter, auxiliary aid, or other reasonable accommodations to be provided. If you do not make your request before your hearing date, your hearing may be rescheduled to when the accommodation can be provided. HAR 17-602.1-5; 17-602.1-13; 17-602.1-30; 17-1703.1-6; 17-1711.1-2

WHAT ARE MY HEARING RIGHTS? You can ask your worker to see the documents and records before the hearing. At the hearing you can say why you think the Department was not correct and you can question the Department's witnesses. You can also bring your own witnesses. You and the Department must agree on the people who will be allowed to observe the hearing. See above for an interpreter. HAR 17-602.1-4 to 5; 17-602.1-30; 17-602.1-36; 17-602.1-38; 17-602.1-40; 17-1703.1-3; 17-1703.1-6

WHAT IS FRAUD? If you do not follow your mandatory reporting requirements, lie, or hide facts, you may be responsible for repaying the value of the benefits you received and other penalties as applicable under the law, including prosecution. HAR 17-604.1; 17-1704-3, 17-1713.1-2; HRS §346-43.5, 710-1063

WHAT ARE MY OTHER RIGHTS?

- **CONFIDENTIALITY:** The Department will not release your information unless it is allowed in program rules or federal laws, needed in specific protective service situations, for fraud investigations, or if you submit a written request to release your information. HAR 17-601; 17-1702-5 to 6; 17-1706-6

NON-DISCRIMINATION: The Department does not discriminate, exclude, or treat people differently on the basis of race, color, national origin, age, disability, or sex/gender (expression or identity) or any protected class under federal or state laws. If you believe that the Department or its service providers have failed to provide services or discriminated against you, you can file a complaint with: Civil Rights Compliance Officer by e-mail at DHSCivilRightsBox@dhs.hawaii.gov, call (808) 586-4955 or 711, fax to (808) 586-4990 or write to: Civil Rights Compliance Officer, P.O. Box 339, Honolulu, HI 96809-0339. DHS discrimination complaint forms (DHS 6000) are available at https://humanservices.hawaii.gov in the Civil Rights Corner under Forms. You can also file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, Office for Civil Rights (OCR), 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, Phone: 1(800) 368–1019, TDD: 1(800) 537–7697.