STATE OF HAWAII
Department of Human Services

Med-QUEST Division

HAWAII CHILD WELLNESS INCENTIVE PILOT PROGRAM (HCWIP) APPLICATION

"Keeping Our Growing Keiki Healthy"

The Hawaii Child Wellness Incentive Pilot program (HCWIP) seeks to ensure the health of children in Hawaii, including early detection of potential illnesses. This program awards a $50.00 gift card to any parent who is a Med-QUEST member for one completed well-child examination per child, per year. The child does not need to be a Med-QUEST member.

Section 1: To be completed by a Medicaid Parent

Medicaid Parent Name (Last, First, MI)	Parent Birthdate	Medicaid ID	Mailing Address	City	State	Zip Code

Child Name (Last, First, MI)	Child Birthdate	Licensed Health Care Professional Name

I, the parent, authorize and release permission for the Licensed Health Care Professional (LHCP) to provide Med-QUEST Division that a well-child examination was completed in order to be eligible for the $50.00 incentive benefit. By signing below, I certify the information provided is true and complete to the best of my knowledge.

1. I, the parent, am actively receiving Medicaid;
2. My child (includes stepchild or adopted child) is unmarried, below 18 years of age;
3. I understand the benefit is per each child once every 12 months; and
4. I understand that the Department of Human Services (DHS) shall confirm the completion of a well-child examination.

I acknowledge the receipt of the $50.00 incentive is contingent on meeting the requirements of the program. I understand that the incentive may be used towards family expenses. Any changes to this authorization form will nullify this agreement and the incentive may be cancelled. This authorization expires once the incentive has been issued.

Medicaid Parent Signature	Date of Signature	Phone Number (Best Contact)	Email Address

Section 2: To be completed by the Licensed Health Care Professional

A well-child examination was conducted for the child on this form.

☐ YES Date of Exam: _____

I certify the information I provided on this form is true to the best of my knowledge.

Licensed Health Care Professional Name (Last, First, MI)	Provider NPI	Medicaid ID	Licensed Health Care Professional Signature

License Health Care Professional Address	Phone Number	Email Address (Optional)

OFFICIAL USE ONLY

1. **DHS 1193 Received on:** _____ **DHS 1193 was completed by the LHCP: Yes** ☐ **No** ☐
2. **$50 Incentive Card No.:**_____ **Notification Notice Date sent on:** _____

Validated Issuer Name	**Issuer Signature**	**Date Signed**

Medicaid Parent's Instructions on How to Submit a Completed/signed Paper Application DHS 1193 through the HCWIP portal:

Hawaii CWIP
medquest.hawaii.gov

The Medicaid Parent may upload the completed paper application to their online account. Scan the QR code to the link to the HCWIP web page and click on "Create An Account" to create an account or "Log In". Click on "Submit New Application", and click on "Upload Application" button, check the box "Provider has signed attached PDF", then the "Submit" button. For other options of how to return the signed/completed form by the LHCP is located on the back of this form. Thank you, we look forward to serving you.

INSTRUCTIONS

DHS 1193 (07/2023)

Hawaii Child Wellness Incentive Pilot Program (HCWIP) Application

"Keeping Our Growing Keiki Healthy"

PURPOSE:

The DHS 1193, "Hawaii Child Wellness Incentive Pilot program (HCWIP) Application" form shall be completed by a Medicaid parent to apply for the $50 incentive benefit for each eligible child, once every 12 months upon a successful completion of the well-child examination as required by the Hawaii Child Wellness Program. The child does not need to be a Med-QUEST member.

GENERAL INSTRUCTIONS:

The DHS 1193 shall be completed by the Medicaid parent, one for each child prior to the appointment and signed by a Licensed Health Care Professional (LHCP) who conducted the well-child examination. The Med-QUEST Division (MQD) staff shall process the application per program requirements.

Section 1: MEDICAID PARENT: This information shall be completed prior to the appointment:

A. Medicaid parent name;
B. Medicaid parent birthdate;
C. Medicaid ID;
D. Mailing address;
E. Child name;
F. Child birthdate;
G. LHCP Name (who will be conducting the well-child examination);
H. Medicaid parent signature and date of signature. The signature acknowledges and certifies that information provided is completed/true and to authorize/release permission to the LHCP to validate a well-child examination was completed/attempted;
I. Phone number (best contact); and
J. Email address

Section 2: Licensed Health Care Professional

This section shall be completed by LHCP. When the LHCP is not known to Medicaid, the following must be completed and signed to validate and certify an examination was completed on the paper DHS 1193 application. The well-child examination shall be considered complete provided there is supporting documentation in the child's records:

A. The LHCP shall print/sign his/her name, Provider National Provider Identifier (NPI), Medicaid ID as applicable, date of the exam, Licensed Professional's address, phone number, and email address (optional).
B. The completed/signed paper DHS 1193 form shall be returned to the Medicaid parent for submittal to DHS/MQD for the incentive payment.
C. To electronically submit the DHS 1193, the Medicaid LHCP shall use the confirmation code provided by the Medicaid parent to locate the application through the online portal at https://medquest.hawaii.gov/cwip or scan the QR code to enter the completion of the well-child examination through the HCWIP portal.

For Official Use Only: The MQD shall leverage available data sources to validate the completion of the well-child examination. The data sources available shall be but not limited to EPSDT program, claims submission, and health plans for child(ren) known to Medicaid. This section shall be completed by MQD Admin to validate that an incentive card has been issued to the parent.

Submit the completed/signed paper DHS 1193 form to:
Department of Human Services/Med-QUEST Division, Attn: HCWIP

Mailing Address: P.O. Box 700190
Kapolei, HI 96709

Physical Address: 601 Kamokila Blvd, RoomC518
Kapolei, HI 96707-2021

Phone: 833-909-3631

FAX: (808) 692-8173

Email: HCWIP@dhs.hawaii.gov

Online portal at: https://medquest.hawaii.gov/cwip

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FILING/DISTRIBUTION INSTRUCTIONS:

MQD shall maintain a copy of all completed DHS 1193 in the designated Electronic Case Maintenance (ECM) folder.