HAWAI'I CHILD WELLNESS INCENTIVE PILOT PROGRAM (HCWIP) APPLICATION

"Keeping Our Growing Keiki Healthy"

The Hawai'i Child Wellness Incentive Pilot program (HCWIP) seeks to ensure the health of children in Hawai'i, including early detection of potential illnesses. This program awards a $50.00 gift card to any parent who is a Medicaid/QUEST beneficiary for one completed well-child examination per child, per year.

Section 1: To be completed by Medicaid Parent **PLEASE PRINT CLEARLY**

_____ _____ _____
Medicaid Parent Name (Last, First, MI) Parent Birthdate Parent Medicaid ID

_____
Mailing Address City State Zip Code

_____ _____
Phone Number (Best Contact) Email Address

_____ _____ _____
Child's Name Child's Birthdate Licensed Health Care Professional Name

I, the parent, authorize and release permission for the Licensed Health Care Professional (LHCP) to provide to the 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 (child does not need to be a Med-QUEST member);
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

……

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.

_____ _____ _____ _____
LHCP (Last, First, MI) Provider NPI Medicaid ID LHCP Signature

_____ _____ _____
LHCP Address Phone Number Email Address (Optional)

INSTRUCTIONS

DHS 1193 (Rev. 05/2024)

Hawai'i Child Wellness Incentive Pilot Program (HCWIP) Application

"*Keeping Our Growing Keiki Healthy*"

PURPOSE: The DHS 1193, "Hawai'i Child Wellness Incentive Pilot program (HCWIP) Application" form shall be completed by a Medicaid/QUEST beneficiary parent to apply for the $50 incentive benefit for each eligible child, per year upon successful completion of a well-child examination as required by the Hawai'i Child Wellness Program. The child does not need to be a Med-QUEST beneficiary.

GENERAL INSTRUCTIONS: The DHS 1193 form shall be completed for each child prior to the examination and certified by the Licensed Health Care Professional (LHCP) who conducted the well-child examination. The Med-QUEST Division (MQD) staff shall process the application per program requirements. Complete this application by printing clearly.

Section 1: MEDICAID PARENT: This section shall be completed by the Medicaid parent.

A. Medicaid parent name
B. Medicaid parent birthdate
C. Medicaid ID
D. Mailing address
E. Phone number (Best Contact)
F. Email address
G. Child's name
H. Child's birthdate
I. LCHP Name who will be conducting the well-child examination
J. Medicaid parent signature and date of signature. The signature certifies that information provided is true and complete and releases permission to the LHCP to validate that a well-child examination was completed.

Section 2: LICENSED HEALTH CARE PROFESSIONAL: This section shall be completed and signed by the LHCP to validate and certify completion of examination. The LHCP shall check "Yes" if an exam was completed and provide the date of the exam. The LHCP shall print and sign their name, include their National Provider Identifier (NPI), Medicaid ID as applicable, date of the exam, address, phone number, and email address (optional).

COMPLETED AND SIGNED DHS 1193 FORM SHALL BE SUBMITTED TO:
Department of Human Services/Med-QUEST Division, Attn: HCWIP

Mailing Address: P.O. Box 700190
Kapolei, HI 96709
Phone: (833) 909-3631
Email: HCWIP@dhs.hawaii.gov

Physical Address: 601 Kamokila Blvd, Room 518
Kapolei, HI 96707
Fax: (808) 900-7978
Online portal at: https://medquest.hawaii.gov/cwip

Hawaii CWIP

How to submit through the HCWIP portal:
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.

FILING/DISTRIBUTION INSTRUCTIONS: MQD shall maintain a copy of all completed DHS 1193 forms in the designated Electronic Case Maintenance (ECM) folder.