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Med-QUEST Division
Clinical Standards Office
P. O. Box 700190
Kapolei, Hawaii 96709-0190

May 18, 2010

MEMORANDUM

MEMO #
ACS M10-07

TO: Dialysis Nephrologists and Facilities

FROM: Kenneth S. Fink, MD, MGA, MPH KF
Med-QUEST Division Administrator

SUBJECT: COVERAGE OF DIALYSIS SERVICES AS EMERGENCY SERVICES FOR ELIGIBLE COMPACT OF FREE ASSOCIATION MIGRANTS AND LEGALLY RESIDING IMMIGRANTS

The Med-QUEST Division (MQD) issues this memo to provide clarification on the coverage of dialysis services under Medicaid's emergency medical assistance. The instructions in this memo pertain only to dialysis services covered under Medicaid's emergency medical coverage. The policies and procedures for dialysis covered under other Medicaid programs, such as QUEST and QUEST Expanded Access (QExA), do not change.

MQD will reimburse for outpatient dialysis services provided at Medicare approved dialysis facilities in Hawaii to those individuals eligible for emergency medical assistance, effective July 1, 2010. Those eligibility requirements include:

- Not eligible for federal medical assistance; and
- Would be eligible for federal medical assistance except for citizenship or residency.

All Basic Health Hawaii (BHH) enrollees are eligible for outpatient dialysis coverage through emergency medical assistance. Inpatient dialysis is covered as part of the BHH inpatient hospitalization benefit. Non-pregnant adult individuals from Compact of Free Association (COFA) nations and immigrants legally residing in the United States for less than five years who are not enrolled in BHH may be eligible for dialysis coverage through emergency medical assistance if they meet the above requirements.

COFA migrants and qualified aliens who are age 18 years or younger and pregnant women may be eligible for full Medicaid coverage, including dialysis services, through the QUEST or QExA programs.

The emergency coverage for outpatient dialysis will be authorized for a period of no more than 12 months at one time and cover only the following dialysis-related codes for nephrologists and dialysis facilities. Although medical non-dialysis services provided to BHH enrollees are billable to QUEST health plans, claims for dialysis services under Medicaid's emergency medical assistance must be submitted to MQD's fiscal agent, Affiliated Computer Services (ACS).

Dialysis Nephrologists			
CPT Code	Code Description	Comments	Rate*
90958	ESRD related services monthly, for patients 12-19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 2-3 face-to-face physician visits per month.	For emergency dialysis eligible patients who are 19. Ages up through 18 are fully covered under either QUEST or QExA.	$265.66
90959	ESRD related services monthly, for patients 12-19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 1 face-to-face physician visits per month.	For emergency dialysis eligible patients who are 19. Ages up through 18 are fully covered under either QUEST or QExA.	$174.23
90961	ESRD related services monthly, for patients 20 years of age and older; with 2-3 face-to-face physician visits per month.		$141.94
90962	ESRD related services monthly, for patients 20 years of age and older; with 1 face-to-face physician visit per month.		$102.26
90965	ESRD related services for home dialysis per full month, for patients 12-19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents.	For emergency dialysis eligible patients who are 19. Ages up through 18 are fully covered under either QUEST or QExA.	$266.34
90966	ESRD related services for home dialysis per full month, for patients 20 years of age and older.		$140
90969	ESRD related services for dialysis less than a full month of service, per day; for patients 12-19 years of age.	For emergency dialysis eligible patients who are 19. Ages up through 18 are fully covered under either QUEST or QExA.	$9.19
90970	ESRD related services for dialysis less than a full month of service, per day; for patients 20 years of age and older.		$4.93

Dialysis Facilities				
Rev Code		Code Description	Comments	Rate*
821		Hemodialysis Composite		$130.04
841		Continuous Ambulatory Peritoneal Dialysis (CAPD) Composite		$57.00
851		Continuous Cycling Peritoneal Dialysis (CCPD) Composite		$56.31
634		Epogen< 10,000 units	May be given intravenously or subcutaneously. Multiple units per session are NOT permitted. Document NDC #.	$38.40
635		Epogen ≥ 10,000 units	Same as above	$67.20
636	J1756	Iron (Venofer)	1 unit = 1 mg. Limited to 100 units (100 mg) per session and 1000 units / 10 sessions (1 gm) per month. Document NDC #. Use when ferretin is </= 800.	$0.365 per 1 mg
	J2916	Iron (Ferrlecit)	1 unit = 12.5mg. Limited to 10 units (125 mg) per session and 80 units / 8 sessions (1 gm) per month. Document NDC #. Use when ferritin is </= 800.	$4.569 per 12.5 mg
	J0690	Cefazolin	1 unit = 500 mg. Bill appropriate units as given. Document NDC #.	$0.631 per 500 mg
	J1580	Gentamicin	1 unit = 80 mg. Bill appropriate units as given. Document NDC #.	$0.88 per 80 mg
	J3260	Tobramycin	1 unit = 80 mg. Bill appropriate units as given. Document NDC #.	$2.27 per 80 mg
	J3370	Vancomycin	1 unit = 500 mg. Bill appropriate units as given. Document NDC #.	$3.198 per 500 mg

*Rate listed is the current Medicaid Fee-for-Service (FFS) rate as of May 10, 2010 and is subject to change.

Submitting an Application for **Emergency Dialysis Services**

Dialysis providers are encouraged to assist clients in applying for emergency medical assistance for dialysis, which will be reimbursed through our fee-for-service-program. The application must be accompanied by clinical notes documenting the diagnosis, the dialysis orders, and the estimated duration of dialysis treatment. The application will be processed to allow an emergency period to be open for at most 12 months at one time and allow payment of claims using the dialysis-related codes listed above.

For clients who are enrolled in BHH:

For clients already receiving dialysis at the time of transition into BHH on July 1, 2010, MQD will work with dialysis facilities ahead of time to identify these clients and automatically open an emergency period

to allow for the dialysis-related codes above to pay. The procedure described below need not be completed for these transitioning BHH clients at the beginning of the program.

For BHH clients who will need dialysis services after BHH has already started, please send the DHS 1149A (see attachment), completed with Client's name, Medicaid ID number, the date of emergency medical services under Part IA (the end date for dialysis may be listed as "ongoing" or "indefinite"), and the checklist for "Dialysis Services" under Section 5B. Send the DHS 1149A with attached documents specified in the checklist to the MQD/Clinical Standards Office by mail or fax.

DHS/MQD/Clinical Standards Office
P.O. Box 700190
Kapolei, Hawaii 96709-0190
Fax: 808-692-8131

For clients who are NOT in BHH and may be eligible for emergency medical assistance:

Complete the DHS 1149A as above. In addition, please also complete an Aid to Disabled Review Committee (ADRC) packet (DHS 1180, DHS 1127, and DHS 1128, see attachments with instructions) to qualify the individual for disability. Please also assist these individuals in filling out an Application for Medical Assistance form (see attachment). Send the completed DHS 1149A with attached documents specified in the checklist, the completed ADRC packet, and the completed Medical Assistance application to the MQD/Eligibility Branch by mail or fax. The applicant may also take the packet to the MQD Eligibility Office.

DHS/MQD/Eligibility Branch
P.O. Box 3490
Honolulu, Hawaii 96811-3490
Fax: 808-587-3543

Prior to the end of the 12 month period, a renewal form will be sent by the Eligibility Branch to the client to determine continued eligibility. Clinical documentation to complete the DHS 1149A will be requested from the provider.

Submitting Claims for Emergency Dialysis Services

All claims for emergency dialysis services must be submitted to ACS electronically or by mail at the address below:

ACS – Hawaii Medicaid Fiscal Agent
P.O. Box 1220
Honolulu, Hawaii 96804-1220

For Nephrologists, submit CPT codes above for reimbursement using form CMS 1500 as normal.

For Dialysis Facilities, submit revenue codes above for reimbursement using form UB 04. Bill only one composite dialysis revenue code, 821, 841, or 851, per session. On a separate line, if applicable, bill only one epogen revenue code, either 634 or 635, per session. Note that multiple units of epogen per session are NOT permitted. Epogen can be given either parenterally or subcutaneously. On separate lines, if applicable, bill revenue code 636 with the appropriate J code for any of the above parenteral drugs (iron, cefazolin, tobramycin, gentamicin, or vancomycin) given during dialysis. For these drugs, bill the

appropriate units given. For intravenous iron, bill either Venofer or Ferrlecit, and note the limits for these drugs. For all drugs billed, the NDC number must be documented in order for the claim to be paid. Medicaid is federally mandated to require NDC information (NDC numbers, NCPDP billing units, and NCPDP quantities for prescription drugs. Memorandum ACS M08-02, issued on February 15, 2008, details these requirements. The specific drugs listed above are the only drugs covered in the emergency coverage for outpatient dialysis. Claims for other prescription medications should be submitted to the enrollee's BHH plan. Please see the attached UB 04 example. Facilities are allowed to span bill.

If there are any questions or concerns regarding this memo, please contact the Clinical Standards Office at 808-692-8121.

Attachments

REVIEW OF MEDICAL CLAIMS FOR INDIVIDUALS ELIGIBLE UNDER EMERGENCY MEDICAL ASSISTANCE

TO: MQD/CSO-Medical Consultant

FROM: Eligibility Worker's Name: ____________________

RE (Client's Name): ____________________

No. of Pages Attached: ______

EB/Sect/Unit: ______

Case No.: ______

PART I: ELIGIBILITY WORKER COMPLETES THIS SECTION (For Dialysis Services, the dialysis facility may complete this section.):

A. **Emergency medical services were provided from ______________ to ______________.**

B. **The following checklists confirm that the documents being submitted contain all necessary information to determine that the medical services meet the requirements of emergency medical services.**

1. HOSPITALIZATION:

- ☐ Dates of service;
- ☐ Name of hospital;
- ☐ Admission history and physical examination;
- ☐ Discharge summary; AND
- ☐ Physician and nursing progress notes for the period recipient is requesting coverage.

2. EMERGENCY ROOM VISIT:

- ☐ Date of service;
- ☐ Name of facility;
- ☐ Emergency room record; AND
- ☐ Emergency room physician's written or dictated documentation.

3. OFFICE OR CLINIC VISIT:

- ☐ Date(s) of service;
- ☐ Name of provider; AND
- ☐ Physician progress note for each date of service.

4. LABORATORY, RADIOLOGY, OR OTHER DIAGNOSTIC SERVICES:

- ☐ Date(s) of service;
- ☐ Name of provider;
- ☐ Physician progress note(s) justifying service; AND
- ☐ Results of test(s).

5. DIALYSIS SERVICES

- ☐ Date(s), include duration of treatment which may be indefinite;
- ☐ Name of Dialysis Facility;
- ☐ Name of Attending Nephrologist;
- ☐ Facility progress notes and/or Physician dialysis orders indicating type of dialysis, frequency, and duration of dialysis need.

PART II: MEDICAL CONSULTANT COMPLETES THIS SECTION:

A. **Emergency medical services cannot be determined without the following information/documents:**

____

____

____

B. **Based on the submitted documentation, the following determination(s) have been made:**

PROVIDER	DATES OF SERVICE	ELIGIBLE FOR PAYMENT	NOT ELIGIBLE FOR PAYMENT

Medical Consultant's Signature: ____________________ Date: ______________

INSTRUCTIONS

DHS 1149A (03/10)
REVIEW OF MEDICAL CLAIMS FOR INDIVIDUALS ELIGIBLE UNDER EMERGENCY MEDICAL ASSISTANCE

PURPOSE:
The DHS 1149A "Review of Medical Claims for Individuals Eligible Under Emergency Medical Assistance," will serve as a referral form between staff of the Eligibility Branch (EB) and the Clinical Standards Office (CSO) to review claims of emergency medical services for payment. The EB staff will provide all the necessary documentation needed to confirm the medical services that were provided to eligible aliens and citizens of a Compact of Free Association (COFA) nation. The CSO-Medical Consultant will determine if the service provided to the individual meets the definitions of emergency medical services and notify EB staff which providers and the service dates that coupons are to be issued.

GENERAL INSTRUCTIONS:

1. Type or print legibly when completing form DHS 1149A.
2. The eligibility worker (EW) shall complete all of Part I, and attach all necessary supporting documents.
3. Medical Consultant shall complete Part II.

SPECIFIC INSTRUCTIONS:

1. The EW shall complete Eligibility Worker's Name, EB/Sect/Unit, Name of Client, Case No., and No. of Pages Attached fields.
2. **Part I – Section A**: The EW shall enter the start and end date emergency services were provided.
3. **Part I – Section B – 1, 2, 3, 4, and 5**: The EW shall check the applicable boxes to indicate that the documents that are submitted with DHS 1149A contains all necessary information to determine that the medical services meet the definitions of emergency medical services.
4. **Part II – Section A:** The Medical Consultant shall indicate what additional documents are needed to determine whether the treatment is considered an emergency medical service.
5. **Part II – Section B:** The Medical Consultant shall:

    A. Indicate the determination of the emergency medical service review by completing provider's name, date of service, check off if eligible for payment or not eligible or payment.

    B. Sign and date the DHS 1149A for the final determination.

ADRC REFERRAL AND DETERMINATION/RE-DETERMINATION

PART I: REFERRAL TO ADRC

Completed ADRC Packet Received, Date ____/____/____

1. **APPLICANT/RECIPIENT NAME** ____________________ **DATE OF BIRTH** ____/____/____
   DHS CASE NO. ____________________ **DHS RECIPIENT I.D. NO.** ____________________
2. **TYPE OF REFERRAL:**
   - ☐ ADRC INITIAL DETERMINATION
   - ☐ ADRC REDETERMINATION, DATE LAST ADRC COMPLETED: ____/____/____ (attach a copy of last DHS 1180)
3. **REFERRAL SOURCE:**
   - ☐ DHS: ____________________
     Division / Section / Unit — Name of EW — Phone No. — Fax No.
   - ☐ QUEST HEALTH PLAN: ____________________
     Name of Plan — Contact Person — Phone No. — Fax No.
4. ☐ DHS 1127
   - ☐ DHS 1128 ☐ DHS 1270 or HCFA 2728 submitted instead of DHS 1128
   - ☐ DHS 1147, SUB-ACUTE/LONG TERM CARE/HOSPICE LEVEL OF CARE EVALUATION, IF APPLICABLE, **AND**
   - ☐ ADDITIONAL INFORMATION OR SUPPORTING EVIDENCE FOR PHYSICAL or PSYCHIATRIC DISABILITY FROM THE QUEST HEALTH PLAN OR MEDICAL PROVIDER.

   COMMENTS: ____________________

PART II: DETERMINATION BY ADRC:

1. ☐ UNIT: ____________________ WORKER: ____________________
   - ☐ QUEST HEALTH PLAN: ____________________ CONTACT: ____________________
   - ☐ TREATING PHYSICIAN: ____________________
2. **GAINFUL ACTIVITY DETERMINATION** (based on recipient's DHS 1127 statement, system verification of lack of income, other information sources, confirmed by MQD/CSO staff if needed)
   - ☐ GAINFUL ACTIVITY IS **NOT** POSSIBLE. ☐ GAINFUL ACTIVITY IS POSSIBLE

   COMMENTS: ____________________

   CERTIFIED BY: ____________________
   MQD/CSO Staff — Date
3. **ADRC DETERMINATION:**
   - ☐ NOT DISABLED
   - ☐ TEMPORARILY DISABLED TO: ____/____/____ (NOT ELIGIBLE FOR QExA)
   - ☐ DISABLED MORE THAN 12 MONTHS - MEETS SSI DISABILITY CRITERIA- MAKE REFERRAL to SSA
     - ☐ CONDITION REQUIRES RE-EVALUATION AFTER ONE YEAR ____/____/____
   - ☐ **EFFECTIVE DATE OF QExA COVERAGE:** ____/____/____ ☐ UNABLE TO DETERMINE

   COMMENTS: ____________________

   CERTIFIED BY: ____________________
   Medical/Psychiatric Consultant — Date

PART III: QExA ENROLLMENT: To be completed by Eligibility Worker, if applicant is disabled.

☐ Enrolled, effective ____/____/____ ☐ Not enrolled. Reason: ____________________

INSTRUCTIONS for DHS 1180 (Rev. 03/10)
ADRC REFERRAL AND DETERMINATION/RE-DETERMINATION

PURPOSE:

The DHS 1180, ADRC Referral and Determination/Re-determination form, shall be initiated by DHS staff or the health plans when there is a reason to believe that an applicant/recipient of financial and/or medical assistance may meet the definition of a permanently disabled individual.

GENERAL INSTRUCTIONS:

DHS staff or health plan shall complete Part I of this form to refer an applicant/recipient for evaluation. The Med-QUEST Division Clinical Standards Office (MQD/CSO) Medical/Psychiatric Consultant, Medical Director and CSO staff will complete Part II and return the form to the referring party or the MQD eligibility worker.

SPECIFIC INSTRUCTIONS:

Part I: Referral to ADRC to be completed by the referring party.

1. Indicate the date a complete ADRC packet is received by the referring party. Inclusion of the DHS 1127 and DHS 1128 forms along with the DHS1180 form constitutes a complete ADRC packet. If either the DHS 1127, DHS 1128 or DHS approved substituted forms (see item 5 below) are missing, the packet should be returned to the referring party.
2. Furnish the following identifying data: the applicant/recipient's name, DOB, DHS case #, and DHS recipient ID #.
3. The type of referral should be indicated by checking the appropriate box. For a re-determination, attach the DHS 1180 of the previous determination.
4. DHS staff or health plan should check the appropriate box and complete the identifying data.
5. Indicate what documents are attached to the referral by checking the appropriate boxes:
    a) DHS 1127 and DHS 1128 **are required** for all ADRC referrals from DHS staff or health plans. Exceptions to submission/completion of DHS 1127 are listed in a separate section at the end of this document.
    b) A HCFA 2728 may be substituted for the DHS 1128 for ADRC referrals on applicant/recipients with end stage renal disease. A DHS 1180 and a DHS 1127 forms are still required.
    c) A DHS 1270 may be substituted for the DHS 1128 for applicant/recipients referred by BESSD. A DHS 1180 and a DHS 1127 forms are still required.
    d) DHS 1147 is required for sub-acute, long term care and hospice applicant/recipients ONLY.
    e) Additional information or supporting evidence for physical or psychiatric disability from the QUEST health plan or medical provider.

Part II: Determination by ADRC to be completed by the MQD/CSO Medical/Psychiatric Consultant, MQD/CSO staff or Medical Director.

1. Determination will be addressed to the applicant/recipient's unit case worker, the health plan's contact person or the treating physician.

2. The result of Gainful Activity Determination will be verified by MQD/CSO staff based on the applicant/recipient's statement on the DHS 1127 form, verification of the lack of income in the HAWI system, and other available information sources. If there is incomplete information to make this determination, or if there is question about the information provided, the CSO staff may further investigate. The determination will be marked on the appropriate box.

   a) **"Gainful activity is not possible"** means the education and work experiences of the applicant/recipient meets the requirements for the applicant/recipient to be considered permanently disabled and unable to do any gainful activity.

   b) **"Gainful activity is possible"** means that information shows that the applicant/recipient may be able to perform or is performing gainful activity.

3. MQD/CSO's medical/psychiatric consultant will make the disability determination based on the licensed treating physician/evaluator's statement on the DHS 1128 and the medical records provided. The gainful activity determination will also be used in final determination of disability. The result of the ADRC determination will be indicated by checking the appropriate box(es).

   a) **"Not disabled"** means the applicant/recipient does not have a medical or psychological condition that meets the ADRC disability criteria.

   b) **"Temporarily Disabled To __/__/__"** means the applicant has a medical or psychological condition that will last less than a year. The applicant/recipient would receive medical coverage under QUEST, as not eligible for QExA. Recipient will be referred for a re-evaluation of disability at the end of the disability period.

   c) **"Disabled More Than 12 Months - Meets SSI Disability Criteria-Make Referral to SSA"** means the applicant/recipient has a medical or psychological condition that meets the SSI Disability Criteria. The applicant/recipient shall be referred to the Social Security Administration by the eligibility worker.

   d) **"Condition Requires Re-Evaluation After One Year ___/___/___"** means the applicant/recipient has a medical or psychological condition that may resolve after the initial evaluation. The QExA health plan or eligibility worker will be sent notification one year after initial disability determination completed requiring the applicant/recipient to be re-evaluated for continued disability. Indicate the re-evaluation date in the space provided. (one year from date of determination)

   e) **"Effective Date of QExA Coverage"**. If the applicant/recipient has a medical or psychological condition that meets the requirements for the disability to be considered permanent, he/she is eligible for QExA coverage. MQD/CSO medical/psychiatric consultant or Medical Director will certify the determination by signing, dating and designating the effective date of enrollment to a QExA health plan, which is the 1st day of the second month following the date a complete ADRC packet is received.

   f) **"Unable to Determine"** means the MQD/CSO's medical/psychiatric consultant is unable to make a disability determination. The consultant would explain reason(s) why under "Comments".

Exceptions to submission/completion of DHS 1127:

1. If an applicant/recipient cannot be found, the health plan/evaluator will have to prove good faith effort to locate the applicant/recipient by documenting the following:
   a. Attempt to locate the applicant/recipient by phone at least five times on different days at different times;
   b. Attempt to locate the applicant/recipient by correspondence, including certified letter;
   c. Attempt to locate the applicant/recipient in conjunction with a hospitalization or a medical appointment; and
   d. Coordination of efforts with the applicant/recipient's primary care physician's office to locate the applicant/recipient.

2. If an applicant/recipient refuses to complete DHS 1127, the applicant/recipient should sign that he/she refuses to complete the form.

In **both** exceptions above, the applicant/recipient must be sent a final certified letter from the health plan/evaluator stating that the ADRC process will be moving forward without the applicant/recipient's input, concurrence or signature. The letter must contain Hawaii Administrative Rules language stating the applicant/recipient has the right to appeal the disability decision and information on how to file an appeal.

Filing Instructions:

Return complete ADRC packet to:

DHS Med-QUEST Division, Clinical Standards Office
P.O. Box 700190
Kapolei, Hawaii 96709-0190
Attn: ADRC
or
Fax to: (808) 692-8131, Attn: Clinical Standards Office

Part III: Enrollment to QExA Health Plan, to be completed by the Eligibility Worker, if applicant is disabled.

1. The BESSD or EB Eligibility Worker (EW) completes this section by indicating the date they completed the QExA enrollment. The form is then faxed back to MQD CSO, (808) 692-8131.
2. If the recipient cannot be enrolled into QExA by the first of the second month following the date a complete ADRC was received by MQD CSO, then the EW must indicate the reason and fax back to CSO.
3. If the findings of the ADRC do not result in a change of health plan, then the EW does not need to complete this portion. No further action is required of the EW.

MEDICAL HISTORY AND DISABILITY STATEMENT

Instructions: It is very important that you read and answer all questions carefully. Your responses may help to determine if you are disabled. You may ask someone such as a relative, friend, eligibility worker, or someone from the health care field to help you complete this form. If someone helps you to complete the form, the answers should, to the extent possible, be in your own words.

Name of potentially disabled individual: ______________________________
Last Name First Name

DHS Recipient ID Number: ____________________ DHS Case Number: ____________________

SOCIAL SECURITY DISABILITY INSURANCE (SSDI) INFORMATION

1. Are you receiving SSDI? [ ] Yes [ ] No
2. Have you ever received SSDI? [ ] Yes [ ] No
3. If yes to #2, why did the SSDI stop? ______________________________
4. Have you applied for social security benefits for your current disability? Check appropriate block(s):
   - [ ] No
   - [ ] Yes, Date applied for benefits: ____________________
   - [ ] My application is pending.
   - [ ] My application has been approved and I am currently or will soon be receiving benefits.
   - [ ] My application was denied. Explain reason given for denial of benefits:

____

____

MEDICAL PROFILE

1. Describe your disability and explain the reason(s) why you are unable to work:

____

____

2. Describe the cause of your disability (i.e. accident, injury, illness, etc):

____

____

3. Describe all treatment(s) prescribed by any physician for your disability:

____

____

4. How often do you see your doctor for treatment? (Check one of the following blocks)
   [ ]weekly [ ] several times a month [ ] monthly [ ] quarterly or more

5. List hospitalization(s) within the past two years, reason for hospitalization(s), and duration(s) of stay:

____

____

____

EDUCATION LEVEL

1. Are you able to understand and communicate in English: [ ] Yes [ ] No

2. Education: Circle the last grade you completed

   1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16

3. List any educational Degree, Diploma, Training, or Certificate received:

   ____

   ____

PREVIOUS WORK EXPERIENCE

1. Have you ever been employed? [ ] Yes [ ] No
   If yes, list the last job and type of work: ____

   ____

   ____

   ____

2. List the date of your last employment and reason(s) why your job was terminated:

   ____

   ____

Check "A" or "B" below and sign. Also, read and initial to acknowledge "C".

A _____ I certify that the information I have provided to be true, accurate, and correct to the best of my knowledge.

B _____ I choose not to complete this form.

Read and initial:

C. _____ I understand that if I am deemed disabled for one year or more, I will be dis-enrolled from my QUEST health plan and enrolled into a QExA health plan. I also understand that I may not be able to continue seeing my current provider(s).

____ ______________
Signature of Applicant/Recipient Date

____ ______________ ______________
Signature of Person Applying for Applicant/Recipient Relationship Date

If applicant/recipient did not complete this form on their own, explain the reason(s) why: ______________

____

____ ______________
Name of Person Who Helped Complete Form Date

****

DHS Remarks: ____

____

INSTRUCTIONS for DHS 1127 (Rev. 11/09)
MEDICAL HISTORY AND DISABILITY STATEMENT

Purpose:

The DHS 1127 shall be completed and submitted to the Aid to Disabled Review Committee (ADRC) to assist in the disability determination by evaluating an individual's medical profile, education level, and previous work experience.

General Instructions:

The applicant/recipient should complete the form in its entirety. If for some reason, the applicant/recipient cannot complete the form, he/she may request assistance from a relative, friend, eligibility worker, or someone in the health care field to help him complete the form. If another person assists in the completion of the form, the answers should still be, to the extent possible, in the applicant/recipient's own words.

Specific Instructions:

1. Enter the name of the potentially disabled person, DHS case number, and DHS recipient identification number.
2. All questions should be read and answered carefully. All responses should be written in the applicant/recipient's words.
3. After completing the form, the applicant/recipient must check either item A. certifying that the information is true and accurate to the best of their knowledge. If the applicant/recipient chooses not to complete the form they should check item B.
4. The applicant/recipient should initial the statement, "I understand that if I am deemed disabled for one year or more, I will be dis-enrolled from my QUEST health plan and be enrolled into a QExA health plan. I also understand that I may not necessarily be able to continue seeing my current provider(s).'
5. If someone is applying on behalf of the applicant/recipient, that person shall sign and date the form and enter their relationship to the applicant/recipient. Provide an explanation as to why the applicant/recipient is unable to complete the form on his/her own behalf.

Exceptions to submission/completion of DHS 1127:

1. If an applicant/recipient cannot be found, the health plan/evaluator will have to prove good faith effort to locate the applicant/recipient by documenting the following:
   a. Attempt to locate the applicant/recipient by phone at least five times on different days at different times;
   b. Attempt to locate the applicant/recipient by correspondence, including certified letter;
   c. Attempt to locate the applicant/recipient in conjunction with a hospitalization or a medical appointment; and,
   d. Coordination of efforts with the applicant/recipient's primary care physician's office to locate the applicant/recipient.

2. If an applicant/recipient refuses to complete DHS 1127, he/she should sign that he/she chooses not to complete the form.

In **both** exceptions above (Item 1 and 2), the applicant/recipient must be sent a final certified letter from the health plan/evaluator stating that the ADRC process will be moving forward without the applicant/recipient's input, concurrence or signature. The letter must contain Hawaii Administrative

Rules language stating the applicant/ recipient has the right to appeal the disability decision and information on how to file an appeal.

Filing Instructions:

Return completed form to:

DHS Med-QUEST Division, Clinical Standards Office
P.O. Box 700190
Kapolei, Hawaii 96709-0190
Attn: ADRC

Or, fax to: (808) 692-8131, Attn: Clinical Standards office

STATE OF HAWAII
Department of Human Services

Med-Quest Division

DISABILITY REPORT

I. Name ______________________________ DOB: _____/_____/_____ Sex: _____
Last First MI Mo Day Yr M/F

LICENSED TREATING PHYSICIAN/EVALUATOR: QUESTIONS MUST BE ANSWERED COMPLETELY and LEGIBLY OR FORM MAY BE RETURNED

II. Describe all significant physical and mental illnesses, accidents, deformities, injuries, illnesses and surgeries related to your patient's disability. Specify date(s) applicable to condition(s) listed and attach copies of all related reports.

____
____
____
____
____
____

III. Current diagnoses (List primary diagnosis first)

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________
6. ______________________________

IV. Indicate your treatment plan and duration of treatment:

____
____
____
____
____
____

V. Explain in detail your patient's functional limitation(s) in doing medium and/or light (sedentary) work. Base your decision on medical evidence and not on subjective judgment. Attach copies of all medical evidence to this report.

____
____
____
____
____
____

VI. LICENSED PHYSICIAN'S STATEMENT OF DISABILITY

Your patient's disability is expected to be:

[ ] **PERMANENT**

[ ] **AT LEAST 12 MONTHS, RE-EVALUATION NEEDED:** ____________________
(MO/YR)

[ ] **TEMPORARY TO:** ____________________
(MO/YR)

______________________________ (Print/Type Name of Licensed Treating Physician/Evaluator)

______________________________ (Signature of Licensed Treating Physician/Evaluator)

______________________________ (Address) (City) (Zip Code)

______________________________ (Phone No.) (Date)

______________________________ (Name of Health Plan)

______________________________ (Medical Provider No. or NPI)

VII. PATIENT ACKNOWLEDGEMENT

______________________________ (Print/Type Name of applicant/recipient)

______________________________ (Patient Contact Number)

______________________________ (Signature of applicant/recipient, Guardian or Representative)

______________________________ (Date)

If Applicant/Client or Guardian or Representative do not sign, indicate reason: ____________

____

FOR OFFICIAL USE ONLY

______________________________ (Case Name)

______________________________ (Case No.)

______________________________ (Worker's Name)

______________________________ (Section Unit)

______________________________ (Unit Address)

______________________________ (Phone No.) (Fax No.)

INSTRUCTIONS

DHS 1128 (Rev. 11/09) DISABILITY REPORT

PURPOSE:

The DHS 1128 Disability Report form shall be initiated either by the health plans or by the Med-QUEST eligibility worker when there is reasonable indication that an applicant/recipient receiving medical assistance from the Department may meet the strict definition of a disabled individual per the most recent edition of the "Disability Evaluation under Social Security". If the applicant/recipient is also applying/receiving financial assistance and requiring a disability determination, the DHS 1128 does not need to be completed as the DHS 1270, Physical Examination Report (for a physical disability) or the DHS 1271, Report of Evaluation (for a psychiatric disability) may be substituted.

GENERAL INSTRUCTIONS

The health plans or Med-QUEST eligibility worker shall require the licensed treating physician/evaluator to complete the DHS 1128 form ONLY IF there is justified reason to believe that an applicant/recipient who is receiving medical assistance from the Department meets the definition of disability as specified by law.

DISABILITY as defined by law is the inability to engage in any substantial gainful activity (SGA) by reason of any medically determinable physical or mental impairment(s) which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than twelve (12) months.

SPECIFIC INSTRUCTIONS:

I. Complete "Name", "DOB" And "Sex" legibly.

II. Licensed treating physician/evaluator shall:

A. Type or print legibly when completing the DHS 1128

B. The form must be completed in its entirety.
   1. Each question listed must be answered as directed.
   2. All answers must meet the legal definition of disability.

C. The form must also contain information of the licensed treating physician/evaluator:
   1. Printed/typed name and signature;
   2. Address, phone number, and date of signature; and,
   3. Name of applicant/recipient's health plan and licensed treating physician's Medicaid provider number or NPI.

D. Each DHS 1128 shall be accompanied by a completed:
   1. DHS 1127, Medical History and Disability Statement form, and
   2. DHS 1180, ADRC Referral and Determination form,

   OR

   3. HCFA 2728 or DHS 1270 may substitute the DHS 1128. These forms shall still be accompanied by a completed DHS 1127 and DHS 1180 as above.

E. Additional medical information may be attached that will enhance the DHS ADRC evaluate for disability determination.

III. Patient acknowledgement of report should be signed by the applicant/recipient or guardian or representative. If the applicant/ recipient does not sign, indicate reason.

IV. "Official Use Only": This section to be completed by DHS eligibility worker if ADRC is initiated by Eligibility Branch or by Clinical Standards Office staff when ADRC packet is received.

V. Return completed forms to:

DHS Med-QUEST Division, Clinical Standards Office
P.O. Box 700190
Kapolei, Hawaii 96709-0190
Attn: ADRC

Or, fax to: (808) 692-8131, Attn: Clinical Standards Office

State of Hawaii
Department of Human Services

Med-QUEST Division

Medical Assistance Application

Date Received by DHS

OFFICIAL USE ONLY
Organization Assisting with Application

Case Name ____

Case Number ____

Worker's Name ____

Section/Unit/EW Code ____

☐ FS/HQ Combo ☐ Medical Only ☐ Upfront AF/GA

1. Please tell us who you are and where you live. This person will receive all mail and phone calls. Also write your name and information in number 3A.

Last Name	First Name	Middle Initial	Best Phone Number to Call	Email Address
Address (Where you live)		Apartment Number	City, State, and Zip Code	
Mailing Address (If it is different from where you live)			What Language Do You Speak Best? *(We will get you a FREE interpreter—see page 7.)*	

2. Please check YES or NO in the boxes below. If you check YES, please complete.

YES	NO		
☐	☐	**A.**	**Is anyone who wants medical assistance pregnant?** *(Unborn children may be counted in the pregnant woman's household size.)* Name ____ Due Date ____ Number of children expected ____
☐	☐	**B.**	**Was the pregnancy confirmed by a home pregnancy test or health care provider?** *(If the answer is NO, we will request verification.)*
☐	☐	**C.**	**Is anyone who wants medical assistance 18-20 years old and claimed as a tax dependent?** *(The tax dependent's parents' or legal guardians' income is counted for the QUEST program.)* Name ____
☐	☐	**D.**	**Is anyone self employed?** *(You may get business expenses deducted.)* Name ____
☐	☐	**E.**	**Is anyone who wants medical assistance in a medical institution or applying for long-term care placement, home and community-based services, DD/MR, or PACE?** *(Program names are listed on page 8. You may be asked to provide more information about assets you owned.)* Name ____ Nursing Home Name ____ Placement Date ____
☐	☐	**F.**	**Is anyone who wants medical assistance 0-18 years old and has an absent or deceased parent?** *(You may be asked to complete more forms.)* Name ____
☐	☐	**G.**	**Is anyone blind, disabled, or 65 years old or older?** *(You may receive income deductions and help with unpaid medical bills.)* Name ____

3. **Please tell us about yourself and who lives in your household. List yourself first and use legal names. Write only family members who are responsible for each other, such as spouses, children under 19 years old, and the children's parents. Attach another paper if there are more than 8 persons.**

- We need a social security number and citizenship information for each person who wants medical assistance.
- We do not need a social security number and citizenship information if a person does not want medical assistance (non-applicant). However, we may ask for more information if a social security number is not provided.

A. **Last Name**____________________
First Name____________________
Middle Initial________
Date of Birth ____ / ____ / ____ (Month / Day / Year)
Age____________

Wants Medical Assistance
☐ Yes
☐ No

Sex
☐ Male
☐ Female

Relationship to You
☐ Self
☐ Spouse
☐ Child
☐ Stepchild
☐ Other (specify): __________

Marital Status
☐ Single
☐ Married
☐ Separated
☐ Divorced
☐ Widowed

Citizenship (optional for non-applicants)
☐ U.S. or U.S. National
☐ CFA Individual
☐ Lawful Permanent Resident
Entry Date:__________
☐ Other (specify): __________

Ethnicity (optional)
☐ Caucasian
☐ Chinese
☐ Filipino
☐ Hawaiian
☐ Japanese
☐ Other (specify): __________

SOCIAL SECURITY NUMBER (optional for non-applicants) ____________________

B. **Last Name**____________________
First Name____________________
Middle Initial________
Date of Birth ____ / ____ / ____ (Month / Day / Year)
Age____________

Wants Medical Assistance
☐ Yes
☐ No

Sex
☐ Male
☐ Female

Relationship to You
☐ Self
☐ Spouse
☐ Child
☐ Stepchild
☐ Other (specify): __________

Marital Status
☐ Single
☐ Married
☐ Separated
☐ Divorced
☐ Widowed

Citizenship (optional for non-applicants)
☐ U.S. or U.S. National
☐ CFA Individual
☐ Lawful Permanent Resident
Entry Date:__________
☐ Other (specify): __________

Ethnicity (optional)
☐ Caucasian
☐ Chinese
☐ Filipino
☐ Hawaiian
☐ Japanese
☐ Other (specify): __________

SOCIAL SECURITY NUMBER (optional for non-applicants) ____________________

C. **Last Name**____________________
First Name____________________
Middle Initial________
Date of Birth ____ / ____ / ____ (Month / Day / Year)
Age____________

Wants Medical Assistance
☐ Yes
☐ No

Sex
☐ Male
☐ Female

Relationship to You
☐ Self
☐ Spouse
☐ Child
☐ Stepchild
☐ Other (specify): __________

Marital Status
☐ Single
☐ Married
☐ Separated
☐ Divorced
☐ Widowed

Citizenship (optional for non-applicants)
☐ U.S. or U.S. National
☐ CFA Individual
☐ Lawful Permanent Resident
Entry Date:__________
☐ Other (specify): __________

Ethnicity (optional)
☐ Caucasian
☐ Chinese
☐ Filipino
☐ Hawaiian
☐ Japanese
☐ Other (specify): __________

SOCIAL SECURITY NUMBER (optional for non-applicants) ____________________

D. **Last Name**____________________
First Name____________________
Middle Initial________
Date of Birth ____ / ____ / ____ (Month / Day / Year)
Age____________

Wants Medical Assistance
☐ Yes
☐ No

Sex
☐ Male
☐ Female

Relationship to You
☐ Self
☐ Spouse
☐ Child
☐ Stepchild
☐ Other (specify): __________

Marital Status
☐ Single
☐ Married
☐ Separated
☐ Divorced
☐ Widowed

Citizenship (optional for non-applicants)
☐ U.S. or U.S. National
☐ CFA Individual
☐ Lawful Permanent Resident
Entry Date:__________
☐ Other (specify): __________

Ethnicity (optional)
☐ Caucasian
☐ Chinese
☐ Filipino
☐ Hawaiian
☐ Japanese
☐ Other (specify): __________

SOCIAL SECURITY NUMBER (optional for non-applicants) ____________________

PLEASE GO TO THE NEXT PAGE AND ANSWER ALL QUESTIONS

E. **Last Name**____________________

First Name____________________

Middle Initial__________

Date of Birth (Month / Day / Year) _____ / _____ / _____

Age_______________

Wants Medical Assistance
- ☐ Yes
- ☐ No

Sex
- ☐ Male
- ☐ Female

Relationship to You
- ☐ Self
- ☐ Spouse
- ☐ Child
- ☐ Stepchild
- ☐ Other (specify): __________

Marital Status
- ☐ Single
- ☐ Married
- ☐ Separated
- ☐ Divorced
- ☐ Widowed

Citizenship (optional for non-applicants)
- ☐ U.S. or U.S. National
- ☐ CFA Individual
- ☐ Lawful Permanent Resident Entry Date:__________
- ☐ Other (specify): __________

Ethnicity (optional)
- ☐ Caucasian
- ☐ Chinese
- ☐ Filipino
- ☐ Hawaiian
- ☐ Japanese
- ☐ Other (specify): __________

SOCIAL SECURITY NUMBER (optional for non-applicants) ____________________

F. **Last Name**____________________

First Name____________________

Middle Initial__________

Date of Birth (Month / Day / Year) _____ / _____ / _____

Age_______________

Wants Medical Assistance
- ☐ Yes
- ☐ No

Sex
- ☐ Male
- ☐ Female

Relationship to You
- ☐ Self
- ☐ Spouse
- ☐ Child
- ☐ Stepchild
- ☐ Other (specify): __________

Marital Status
- ☐ Single
- ☐ Married
- ☐ Separated
- ☐ Divorced
- ☐ Widowed

Citizenship (optional for non-applicants)
- ☐ U.S. or U.S. National
- ☐ CFA Individual
- ☐ Lawful Permanent Resident Entry Date:__________
- ☐ Other (specify): __________

Ethnicity (optional)
- ☐ Caucasian
- ☐ Chinese
- ☐ Filipino
- ☐ Hawaiian
- ☐ Japanese
- ☐ Other (specify): __________

SOCIAL SECURITY NUMBER (optional for non-applicants) ____________________

G. **Last Name**____________________

First Name____________________

Middle Initial__________

Date of Birth (Month / Day / Year) _____ / _____ / _____

Age_______________

Wants Medical Assistance
- ☐ Yes
- ☐ No

Sex
- ☐ Male
- ☐ Female

Relationship to You
- ☐ Self
- ☐ Spouse
- ☐ Child
- ☐ Stepchild
- ☐ Other (specify): __________

Marital Status
- ☐ Single
- ☐ Married
- ☐ Separated
- ☐ Divorced
- ☐ Widowed

Citizenship (optional for non-applicants)
- ☐ U.S. or U.S. National
- ☐ CFA Individual
- ☐ Lawful Permanent Resident Entry Date:__________
- ☐ Other (specify): __________

Ethnicity (optional)
- ☐ Caucasian
- ☐ Chinese
- ☐ Filipino
- ☐ Hawaiian
- ☐ Japanese
- ☐ Other (specify): __________

SOCIAL SECURITY NUMBER (optional for non-applicants) ____________________

H. **Last Name**____________________

First Name____________________

Middle Initial__________

Date of Birth (Month / Day / Year) _____ / _____ / _____

Age_______________

Wants Medical Assistance
- ☐ Yes
- ☐ No

Sex
- ☐ Male
- ☐ Female

Relationship to You
- ☐ Self
- ☐ Spouse
- ☐ Child
- ☐ Stepchild
- ☐ Other (specify): __________

Marital Status
- ☐ Single
- ☐ Married
- ☐ Separated
- ☐ Divorced
- ☐ Widowed

Citizenship (optional for non-applicants)
- ☐ U.S. or U.S. National
- ☐ CFA Individual
- ☐ Lawful Permanent Resident Entry Date:__________
- ☐ Other (specify): __________

Ethnicity (optional)
- ☐ Caucasian
- ☐ Chinese
- ☐ Filipino
- ☐ Hawaiian
- ☐ Japanese
- ☐ Other (specify): __________

SOCIAL SECURITY NUMBER (optional for non-applicants) ____________________

PLEASE GO TO THE NEXT PAGE AND ANSWER ALL QUESTIONS

4. Please tell us ALL income your household gets each month. If you have no income, complete A and go to number 5.

☐ A. Check here if your household has no income. Tell us how your food, rent, and other living costs are paid:

____

____

B. Check YES or NO for **every type** of income listed. If YES, please write information in the boxes and **attach document copies**. Write the person's name and monthly gross amount **(before taxes and deductions—not take home pay)**. Completing this information will help us process your application faster.

YES	NO	Household Income	Person Receiving Income	Monthly Gross Amount
☐	☐	Job: Employer's Name 1. 2. 3.	 1. 2. 3.	Total for **Whole Month** 1. $ 2. $ 3. $
☐	☐	Self-Employment Income		$
☐	☐	Social Security Benefits		$
☐	☐	Supplemental Security Income (SSI)		$
☐	☐	Pension/Retirement Income (write who pays you: ____________)		$
☐	☐	Veteran's Benefits		$
☐	☐	Temporary Disability Insurance (TDI) (write who pays you: ____________)		$
☐	☐	Worker's Compensation		$
☐	☐	Unemployment Insurance Benefits (UIB)		$
☐	☐	Insurance Settlements (write who pays you: ____________)		$
☐	☐	School Grants and Scholarships (write type and dates: ____________)		$
☐	☐	Child Support		$
☐	☐	Alimony		$
☐	☐	Child's Income		$
☐	☐	Other Income (please tell us):		$

5. YES ☐ NO ☐ **Does anyone pay for childcare? If YES, please write information in the boxes.** *(You may be allowed these deductions.)*

Person Who Pays	Monthly Cost	Name of Child	Person Providing Care
	$		
	$		
	$		

PLEASE GO TO THE NEXT PAGE AND ANSWER ALL QUESTIONS

6. **Please list ALL household assets as of the first day of this month.**

☐ A. Check here if you are only requesting medical assistance for persons who are 0-18 years old or a pregnant woman and go to number 7.

B. Check YES or NO for **every type** of asset listed. If YES, please write information in the boxes and **attach document copies**. Write the owner's name, bank or company name, and value. Completing this information will help us process your application faster.

YES	NO	Assets	Owner's Name	Bank or Company Name	Dollar Value
☐	☐	Checking Accounts (write all)			$
☐	☐	Savings Accounts (write all)			$
☐	☐	Cash			$
☐	☐	Income Tax Refunds			$
☐	☐	Stocks and Bonds			$
☐	☐	Money Market Accounts, CDs, and Time Certificates			$
☐	☐	IRA, Keogh, and Deferred Compensation			$
☐	☐	Home or Mobile Home			$
☐	☐	Other Houses, Land, and Buildings			$
☐	☐	Burial Plans: Total Number ________			$
☐	☐	Burial Plots: Total Number ________			$
☐	☐	Life Insurance (Surrender Cash Value)			$
☐	☐	Family or Individual Trust Funds			$
☐	☐	Business Equity (Self-Employed)			$
☐	☐	Boats and Trailers			$
☐	☐	Jewelry, Diamonds, Gold, Silver, Etc.			$

7. **Please check YES or NO in the boxes below. If YES, please write information in the boxes.**

YES NO

☐ ☐ **A. Has anyone who needs medical assistance for long-term care, home and community-based services, DD/MR, or PACE sold, traded, or given away money, property, other resources, or assets in the past 5 years?** *(You may not get help if you disposed of assets for less than fair market value.)*

Items Sold, Traded, etc.	Transaction Date	Reason for Sale, Transfer, etc.	Actual Owed	Actual Value	Amount Received
			$	$	$
			$	$	$

☐ ☐ **B. Does anyone who needs nursing home assistance or the person's spouse have an annuity?**

Owner's Name	Annuity Company and Policy Number	Value
		$
		$

8. Please check YES or NO in the boxes below. If YES, please write information in the boxes.

YES NO

☐ ☐ **A. Does anyone listed in Question 3 have private health, dental insurance, vision insurance, long-term care insurance, Medicare, TRICARE, VA benefits, or prescription drug coverage?** *(Other insurance may help pay medical, dental, vision, or drug bills.)*

Person Covered	Insurance Name, Type, and Policy Number	Start Month/Year	Premium Amount
			$
			$

☐ ☐ **B. Has an employer offered health insurance to anyone who is employed?** *(We need to know about employer-sponsored health insurance for the employee only **not** his or her children or spouse.)*

Person Covered	Insurance Name, Type, and Policy Number	Start Month/Year	Employer's Name

☐ ☐ **C. Did anyone lose employer-provided health insurance or extended health care coverage (COBRA) in the past 45 days?**

Person's Name	Last Day Covered

☐ ☐ **D. Has anyone been hospitalized or gone to an emergency room in the past 5 days?** *(We may be able to help pay the bills.)*

Person's Name	Service Dates	Provider (Doctor, Hospital, etc.)

☐ ☐ **E. Does anyone who is blind, disabled, or 65 years old or older have unpaid medical bills the past 3 months?** *(We may be able to help pay the bills.)*

Person's Name	Service Dates	Provider (Doctor, Hospital, etc.)

☐ ☐ **F. Does anyone have medical problems or need medical treatment due to an accident or incident?** *(The responsible party may help pay medical bills.)*

Person's Name	Accident or Incident Dates	Provider (Doctor, Hospital, etc.)

☐ ☐ **G. Does anyone need ongoing medical treatment—doctor visits, prescriptions, etc.?** *(We may be able to help pay the bills.)*

Person's Name	Expected Monthly Cost	Provider (Doctor, Hospital, etc.)

9. Please tell us that you read or had read to you the statement below by signing your name and writing the date.

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 §710-1063. 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 page 11 that I may keep for my information.

Applicant's Signature________________________________ Date__________________

10. Certification by Person Assisting the Applicant in Completing this Application

I helped the applicant complete this application or I am applying for an individual who is unable to act on his/her own behalf. I understand that anyone helping an individual to receive benefits dishonestly is subject to criminal penalties. I certify that the answers on this form ☐ were provided by the applicant/recipient or ☐ are what I personally know about him or her.

Representative's Name (Print)______________ Signature______________ Relationship____________ Telephone Number__________ Date__________

[OFFICIAL USE ONLY: MQD EW NAME (Print)____________________ SIGNATURE____________________ APPLICATION REVIEW DATE_______]

Bilingual and Sign Interpreter Services

☐	Med-QUEST will provide a free bilingual or sign language interpreter. Yes, I need a ________________ language interpreter.	English
☐	Med-QUEST 將會供給您一位免費的雙語翻譯員或手勢語的翻譯員。 是，我要一位 (選一個) ☐普通話 / 國語 (M) ☐廣東話 (C) 的翻譯員。	Chinese
☐	Med-QUEST epwe aora emon chon affou ese kamo, mei sinenap non poraus are pomwen poraus. U, U-mochen emon chon affou non kapasen chuuk.	Chuukese
☐	E kōkua a hā'awi ana ʻo Med-QUEST i kekahi kanaka unuhi ʻōlelo a i ʻole i kekahi kanaka "sign language." ʻAe, makemake au i kekahi kanaka unuhi ʻōlelo.	Hawaiian
☐	Ti Med-QUEST mangted iti libre nga interprete nga makaammo iti nadumaduma a pagsasao (bilingual) wenno pagsasao babaen iti senyal (sign). Wen, masapul ko ti interprete nga Ilokano.	Ilocano
☐	クエストが、無料で、バイリンガルあるいは手話の通訳をつけてくれます。 はい、私は日本語の通訳が必要です。	Japanese
☐	Med-QUEST 에서는 통역이나 수화 통역사를 무료로 제공 합니다. 네, 저는 한국 통역이 필요 합니다.	Korean
☐	Med-QUEST ຈະຈັດຫາ ນາຍພາສາ ທີ່ເວົ້າໄດ້ສອງພາສາ ຫລື ນາຍພາສາກືກ ໃຫ້ຟຣີ. ແມ່ນແລ້ວ, ຂ້າພະເຈົ້າ ຕ້ອງການ ນາຍພາສາລາວ.	Laotian
☐	Med-QUEST enaj lewōj ejelok wōnen juōn rukok ak rukok kin sign. Aet, iaikuj i juōn rukok kajin majōl.	Marshallese
☐	Med-QUEST pahn kahk sawasikida sewesepehn tohn kawehwei ni sohte pweipwei. Ehi, ih anahne tohn kawehwei ohng ni lokoiahn Pohnpeian.	Pohnpeian
☐	O le a saunia ele Med-QUEST se faamatala upu ile gagana poo le faaaogaina o saini ma lima e aunoa mase totogi. Ioe, oute manaomia se faamatala upu ile gagana Samoa.	Samoan
☐	Med-QUEST le proporcionará un intérprete sin cargo bilingüe o de lenguaje de signos. Sí, necesito un intérprete de español.	Spanish
☐	Ang Med-QUEST ay nagbibigay ng libreng interprete na makakaalam ng iba-ibang wika (bilingual) o lenggwahe sa pamamagitan ng senyas (sign). Oo, kailangan ko ang interprete na Tagalog.	Tagalog
☐	ʻE lava he'e Med-QUEST ʻo ʻomai e kau fakatonulea ʻo tatau pe kihe lea moe fakaʻilonga lea ʻaki e nima. ʻIo ʻoku ou fiema'u e fakatonulea.	Tongan
☐	Med-QUEST sẽ cung cấp một thông dịch viên song ngữ hoặc thông dịch viên ra dấu miễn phí. Vâng, tôi cần một thông dịch viên tiếng Việt Nam.	Vietnamese

General Questions and Answers

How long does it take for my application to be processed?
Med-QUEST has up to 45 days from the date it receives your application to approve or deny it. However, if the person who needs medical assistance is blind or disabled, they have 90 days to review it. Pregnant women applications are processed within 5 business days if all questions on the application are completed.

What is the difference between QUEST and Fee-for-Service?
Med-QUEST pays health plans for customers enrolled in QUEST, QUEST-ACE, QUEST-Net, and QUEST Expanded Access (QExA). It pays health care providers for customers not enrolled in a health plan.

If I have Medicare, can I still get Medicaid?
Yes. If you qualify for Medicaid, the state may pay your Medicare premiums.

If I have Medicare, will QUEST Expanded Access (QExA) pay for my prescription drugs?
Some drugs not covered by Medicare may be paid by QUEST Expanded Access (QExA).

Do I enroll in a health plan if my application is approved for the QUEST program?
Yes. If you receive a letter from Med-QUEST that your application is approved for QUEST, you must enroll in a health plan within 10 days. You can choose from several health plans by calling our Customer Service Section at 524-3370 (Oahu) or 1-800-316-8005 (Neighbor Islands). You can also fax your request to 692-7224 (Oahu) or 1-800-576-5504 (Neighbor Islands).

Must I live in Hawaii to apply?
Yes. You must be a Hawaii resident. People who need medical assistance must also plan to live in Hawaii indefinitely.

Can only United States citizens get medical assistance?
No. You can be a United States citizen, United States National, lawful permanent resident, qualified alien, or citizen from the Federated States of Micronesia, Republic of the Marshall Islands, or Republic of Palau.

Will enrolling in QUEST or Fee-for-Service affect my immigration status?
No. It will not affect your immigration status. Call the national U.S. Citizenship and Immigration Services center at 1-800-375-5283 for details.

What are the DD/MR and PACE programs?
These programs are Developmental Disabilities/Mental Retardation (DD/MR) and Program of All Inclusive Care for Elderly (PACE). They provide support services so a person can remain at home or live in a community-based setting.

Important Resources

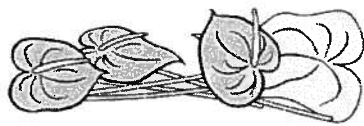
211
Information and referral hotline service sponsored by Aloha United Way. Free call from all islands by dialing 211.

Domestic Violence Legal Hotline
Provides civil legal assistance and advocacy to domestic abuse victims. 531-3771 (Oahu) or www.stoptheviolence.org

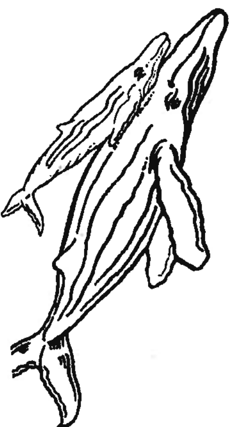
Medicare
Information provided by the Centers for Medicare & Medicaid Services.
1-800-633-4227 or www.medicare.gov

Sage PLUS
Provides statewide health insurance information counseling and referrals to people 60 years or older. 586-7299 (Oahu) or 1-888-875-9229 (Neighbor Islands) or www4.hawaii.gov/eoa/programs/sage_plus/

Executive Office on Aging
Dedicated to the well-being of older adults and their caregivers.
586-0100 (Oahu), 974-2400 (Hawaii), 274-3141 (Kauai), 984-2400 (Maui), 1-800-468-4644 (Molokai), or www4.hawaii.gov/eoa/



Common Questions and Answers



Pregnant Women

How long does it take for my application to be processed?
Med-QUEST will process your application within 5 business days if you answer all questions on the application.

What should I do after the baby is born?
Call your Med-QUEST worker and let her or him know the baby s full name and date of birth. If Med-QUEST needs more information, they will contact you. The baby will stay in the mother s health plan for 30 days.

How long will my medical assistance continue?
You will be covered for 60 days after the baby is born. To continue longer, complete Form 1100 to find out if you are eligible as a non-pregnant adult.

If I am not eligible for Med-QUEST s programs, can I apply for my baby?
Yes. If your baby is eligible, benefits begin on the date Med-QUEST receives the application. Also, if you want your birth expenses covered, Med-QUEST must receive your application within 5 calendar days of the baby s delivery. It would be helpful to complete the application before you go to the hospital, take it with you, and ask the hospital staff to fax it to your local Med-QUEST office.

Children

How long does it take for my application to be processed?
Med-QUEST has up to 45 days from the date it gets your application to approve or deny it. However, if the person who needs medical assistance is blind or disabled, they have 90 days to review it.

How soon can my child get health care?
If the application is approved, benefits begin on the date Med-QUEST received the application.

If my child gets sick before the application is approved, what should I do?
Please call a doctor! Private physicians and community health centers can help you. Tell them you have an application pending with Med-QUEST. If you cannot get help because you don t have health insurance, call your local Med-QUEST office and ask for an emergency processing form (1149). Telephone numbers are listed on the last page of the application. You can also download the form at www.coveringkids.com/library/. After the doctor completes the form, bring it to Med-QUEST and they will review your application.

Will enrolling in a health plan or Fee-for-Service affect my immigration status?
No. It will not affect your child s or family s immigration status. Call the national U.S. Citizenship and Immigration Services center at 1-800-375-5283 for details.

Important Resources

211
Information and referral hotline service sponsored by Aloha United Way. Free call from all islands by dialing 211.

Child Abuse and Neglect
Statewide 24-hour hotline. Call if you think a child is abused or neglected. 832-5300 (Oahu).

WIC
Nutrition program for women, infants, and children. 586-8175 (Oahu) or 1-888-820-6425 (Neighbor Islands).

Head Start
Child development programs that serve children from birth to age 5 years old and their families. www.hawaii.gov/dhs/self-sufficiency/childcare/headstart/

MothersCare Information Line
Operated by Healthy Mothers Healthy Babies Coalition of Hawaii. Links pregnant women to health and community resources. 951-6660 (Oahu), 1-888-951-6661 (Neighbor Islands), or www.hmhb-hawaii.org.

Parent Line
Staffed by professionals specializing in child and adolescent growth and development. 526-1222 (Oahu) or 1-800-816-1222 (Neighbor Islands).

Mikah The Myna Bird has friendly advice…

Regular health check-ups are no Myna matter!

EPSDT provides free **E**arly and **P**eriodic **S**creening, **D**iagnosis, and **T**reatment health services for individuals under 21 years old receiving medical assistance through Med-QUEST's programs.

EPSDT offers:

- complete medical and dental examinations
- hearing, vision, and laboratory tests
- immunizations and tuberculosis skin tests
- assistance with scheduling appointments
- help with arranging transportation

☺ Regular health check-ups can keep you healthy ☺

What is EPSDT?
Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services is a program that provides regular medical and dental check-ups for individuals under 21 years old.

Why should EPSDT concern me?
It is important that children and youth get regular checkups so their doctors find health problems before they become serious.

Who can use this program?
Individuals from birth through 20 years old receiving medical assistance through Med-QUEST's programs.

How can the person get EPSDT services?
Individuals receiving medical assistance get EPSDT services through participating health care providers.

If you need more information, help scheduling an appointment, language interpreter, or transportation assistance, please call 692-8110 (Oahu) or 1-866-836-0957 (free from the Neighbor Islands).

Good health can make all the difference in your life ... and that's no Myna matter!

YOU MAY TEAR OFF AND KEEP

RIGHTS AND RESPONSIBILITIES

WHAT I HAVE THE RIGHT TO EXPECT FROM THE DEPARTMENT:

RIGHT TO CONFIDENTIALITY: Federal and State laws do not allow the Department to release any information I have provided without my written permission unless it is directly related to managing the medical assistance programs.

NO DISCRIMINATION: I will not be treated differently because of my race, color, age, sex, national origin, physical or mental disability, or religious or political beliefs. If I am not satisfied with the way I am treated, I should write as soon as possible to the Department of Human Services Personnel, Civil Rights Compliance Unit, P.O. Box 339, Honolulu, HI 96809-0339 or the U.S. Department of Health and Human Services, Office of Civil Rights/Region IX, 90 7th Street, Suite 4-100, San Francisco, CA 94103-6705, Attention: Regional Manager. I may also call the US DHHS at 1-800-368-1019 (toll free) or 1-415-437-8311 (TDD). I can get a Discrimination Complaint Form, Consent/Release Form, and joint Nondiscrimination Notices in multiple languages at http://hawaii.gov/dhs in the Civil Rights Corner.

FAIR AND FRIENDLY TREATMENT: The Department will make an eligibility determination based on facts within 45 days from the date the application is received by the Department or within 90 days for someone who is applying for medical assistance based on a disability. I will be given correct information and treated with dignity and courtesy at all times.

BILINGUAL, SIGN INTERPRETER, OR OTHER ACCOMMODATIONS: All Department oral and written communication to me will be in English. If I do not understand what I hear or read, I will contact the Department right away. I can get free help to access medical assistance with sign or foreign language interpreters, large print, taped materials, or accessible parking, etc.

RIGHT TO ADVANCE NOTICE AND ADMINISTRATIVE APPEAL: The Department must tell me before they take any action that affects my benefits by mailing me a notice. If I am not satisfied with any decision made by the Department that will affect me, I have 90 days from the date on which the notice is mailed to me to request an administrative appeal. I may ask the Legal Aid Society of Hawaii, another community agency, or anyone else to assist me.

PRE-EXISTING CONDITIONS: Federal law limits when health insurance will not pay for a pre-existing condition. If I enroll in a group health insurance plan that does not cover pre-existing conditions, I can get credit for the time I received medical assistance. I must ask for a certificate of medical coverage within 24 months after my medical assistance coverage ends.

EPSDT: All persons under age 21 can have free regular health and dental check-ups under the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program. Participating physicians, dentists, clinics, and health centers provide EPSDT check-ups, diagnosis, and treatments. If requested, I may also receive help with scheduling appointments and transportation for these checkups.

WHAT THE DEPARTMENT HAS THE RIGHT TO EXPECT OF ME:

SOCIAL SECURITY NUMBER: I am required to provide Social Security Numbers (SSNs) for all persons applying for medical assistance. (42 USC 1320b-7; 42 CFR 435.910(a)) The SSNs are used to verify the income and assets of those applying for medical assistance to determine if they are eligible. I do not have to provide my SSN if I am not applying for medical assistance or if I am a non-lawful alien applying for emergency medical assistance. If I do not provide my SSN, it will not affect my children's eligibility. My SSN will not be shared with U.S. Citizenship and Immigration Service.

CITIZENSHIP: Those persons applying for assistance in my household are U.S. citizens; lawful permanent residents; refugees; asylees; persons granted cancellation of removal, or paroled in the U.S.; nationals of American Samoa or Swain's Island; Cuban, Haitian, or conditional entrants; Amerasian immigrants; honorably discharged or active duty military, or their spouse or dependent children; battered spouse or children, or children of a battered spouse under the Violence Against Women Act; citizens of the Federated States of Micronesia, Marshall Islands, or Palau, or permanently residing in Hawaii under color of law; or otherwise authorized by law to receive assistance. I must provide proof of lawful immigration status unless I am not applying for medical assistance, or I am an alien that entered the U.S. on or after August 22, 1996 and am applying for emergency medical services. (42 CFR 435.910(a))

COOPERATION AND GOOD CAUSE: Help is available to me through the Child Support Enforcement Agency (CSEA) if I need to obtain medical support for my children. I do not have to cooperate with CSEA if it is not in the best interest of my children. Otherwise, I will help my children get medical support by helping CSEA identify the father(s) of my children. If I do not cooperate because I believe it may not be in the best interest of my household, I must provide information to support this. Without good cause, it will not affect my children's medical assistance, however I will not be eligible for medical assistance unless I am pregnant.

THIRD PARTY LIABILITY: I will give the State of Hawaii any health insurance payments or other money received for medical care for the time anyone in my household receives assistance. If I do not cooperate because I believe it may not be in the best interest of my household, I must provide information to support this. Without good cause, it will not affect my children's medical assistance, however I may not be eligible for medical assistance unless I am pregnant.

ASSETS AND OTHER PROPERTIES: I must give the Department information about any asset or property that is owned by my household unless I am only applying for medical assistance for children or as a pregnant woman. If I get rid of any income, asset or property for less money than the fair market value, it may affect my eligibility for nursing facility level care. An annuity purchased after February 8, 2006 must name the State as a remainder beneficiary.

REPORTING ANY CHANGES: I will report to the Department *all* changes about my household within 10 days of when I learn of the changes as they may affect my eligibility for medical assistance. Changes to report include, among other things: income; addresses; living arrangement; marriage/divorce; pregnancy; birth; death; insurance coverage. It also includes the injuries from accidents; receipt, transfer or sale of any asset (i.e. home, car, etc.); or receipt of a Social Security Number. I must also report when anyone enters a hospital or public institution, or moves out of the State of Hawaii.

VERIFICATION OF INFORMATION: The Department may contact Federal, State, and local officials to make sure the information that I provide is true. I agree to help the Department, its agents and contractors, and Federal reviewers and/or auditors if my case is reviewed. The Department may call any bank or other financial institution to get information about the accounts that belong to my household.

PENALTY WARNING: All information given by me on all forms is true and complete to the best of my knowledge. If I give wrong information on purpose or have someone give wrong information on purpose to help me get medical assistance coverage, I may have to pay penalties and/or repay any medical assistance I received.

APPLYING FOR MEDICAL ASSISTANCE

Please check to see that you completed all necessary information on the medical assistance application and it is signed and dated. This will help us process it faster. If the application is incomplete, you may be contacted for more information.

You may take your completed medical assistance application to the Med-QUEST eligibility office near where you live or mail it to the address below. You can also fax it to your local office. If you have questions about your application, please call your local eligibility office.

OFFICE ADDRESSES	MAILING ADDRESSES	TELEPHONE AND FACSIMILE NUMBERS
Oahu Section 801 Dillingham Boulevard, 3rd Floor Honolulu, HI 96817-4582	**Oahu Section** P. O. Box 3490 Honolulu, HI 96811-3490	**Phone 587-3521 or 587-3540** **Fax 587-3543**
Kapolei Unit Kakuhihewa State Office Building 601 Kamokila Boulevard, Room 415 Kapolei, HI 96707-2021	**Kapolei Unit** P. O. Box 29920 Honolulu, HI 96820-2320	**Phone 692-7364** **Fax 692-7379**
East Hawaii Section 88 Kanoelehua Avenue, Room 107 Hilo, HI 96720-4670	**East Hawaii Section** 88 Kanoelehua Avenue, Room 107 Hilo, HI 96720-4670	**Phone 933-0339** **Fax 933-0344**
West Hawaii Section Lanihau Professional Center 75-5591 Palani Road, Suite 3004 Kailua-Kona, HI 96740-3633	**West Hawaii Section** Lanihau Professional Center 75-5591 Palani Road, Suite 3004 Kailua-Kona, HI 96740-3633	**Phone 327-4970** **Fax 327-4975**
Lanai Unit 730 Lanai Avenue Lanai City, HI 96763	**Lanai Unit** P. O. Box 737 Lanai City, HI 96763-0737	**Phone 565-7102** **Fax 565-6460**
Maui Section Millyard Plaza 210 Imi Kala Street, Suite 101 Wailuku, HI 96793-1274	**Maui Section** Millyard Plaza 210 Imi Kala Street, Suite 101 Wailuku, HI 96793-1274	**Phone 243-5780** **Fax 243-5788**
Molokai Unit State Civic Center 65 Makaena Street, Room 110 Kaunakakai, HI 96748	**Molokai Unit** P. O. Box 1619 Kaunakakai, HI 96748-1619	**Phone 553-1758** **Fax 553-3833**
Kauai Unit 4473 Pahee Street, Suite A Lihue, HI 96766-2037	**Kauai Unit** 4473 Pahee Street, Suite A Lihue, HI 96766-2037	**Phone 241-3575** **Fax 241-3583**

YOU MAY TEAR OFF AND KEEP

3a PAT. CNTL #	b. MED. REC. #	4 TYPE OF BILL

5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM	THROUGH	7
99999999	01/01/10	01/01/10	

8 PATIENT NAME a Test, Johnny

9 PATIENT ADDRESS a

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	CONDITION CODES 18–28	29 ACDT STATE	30
01/01/10	M	01/01/10								

31–34 OCCURRENCE CODE / DATE; 35–36 OCCURRENCE SPAN CODE / FROM / THROUGH; 37

38

39–41 VALUE CODES CODE / AMOUNT (a–d)

	42 REV. CD.	43 DESCRIPTION		44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	0821	Hemodialysis Composite				1	130.04		
2	0634	Epogen <10,000 units	NDC# xxxxxxxxxxxxxxxxx			1	38.40		
3	0636	Iron (Venofer)	NDC# xxxxxxxxxxxxxxxx	J1756		100	36.50		
4	0636	Tobramycin	NDC# xxxxxxxxxxxxxxxx	J3260		1	2.27		
23		PAGE 1 OF 1		CREATION DATE		TOTALS	260.59		

Sample

50 PAYER NAME | 51 HEALTH PLAN ID | 52 REL. INFO | 53 ASG. BEN. | 54 PRIOR PAYMENTS | 55 EST. AMOUNT DUE | 56 NPI | 57 OTHER PRV ID

58 INSURED'S NAME | 59 P. REL | 60 INSURED'S UNIQUE ID | 61 GROUP NAME | 62 INSURANCE GROUP NO.

63 TREATMENT AUTHORIZATION CODES | 64 DOCUMENT CONTROL NUMBER | 65 EMPLOYER NAME

66 DX | 67 A B C D E F G H | I J K L M N O P Q | 68

69 ADMIT DX | 70 PATIENT REASON DX a b c | 71 PPS CODE | 72 ECI a b c | 73

74 PRINCIPAL PROCEDURE CODE DATE | a. OTHER PROCEDURE CODE DATE | b. OTHER PROCEDURE CODE DATE | 75

c. OTHER PROCEDURE CODE DATE | d. OTHER PROCEDURE CODE DATE | e. OTHER PROCEDURE CODE DATE

76 ATTENDING NPI QUAL LAST FIRST

77 OPERATING NPI QUAL LAST FIRST

80 REMARKS | 81CC a b c d

78 OTHER NPI QUAL LAST FIRST

79 OTHER NPI QUAL LAST FIRST

THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.