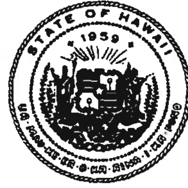
NEIL ABERCROMBIE
GOVERNOR



PATRICIA MCMANAMAN
DIRECTOR

BARBARA A. YAMASHITA
DEPUTY DIRECTOR

STATE OF HAWAII
DEPARTMENT OF HUMAN SERVICES
Med-QUEST Division
Administration
P. O. Box 700190
Kapolei, Hawaii 96709-0190

August 22, 2012

MEMORANDUM ACS M12-06

TO: Nursing Facility Providers, Home and Community Based Services Providers

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

SUBJECT: ANNUITY DOCUMENTATION FOR MEDICAID LONG-TERM CARE SERVICES (LTCS) COVERAGE

The purpose of this memo is to provide information regarding annuities for long-term care services (LTCS) eligibility determination. Since you provide services to Medicaid applicants/beneficiaries that are receiving institutional or community based LTCS, we appreciate any help you can provide to your clients that are receiving these services to facilitate their receiving or maintaining Medicaid eligibility. Continued medical assistance coverage for the Medicaid applicants/beneficiaries you serve may be dependent upon timely and proper submission of the required documents.

The Deficit Reduction Act imposed new requirements regarding the transfer of assets for Medicaid coverage of beneficiaries' LTCS. This memo addresses the requirements regarding annuities. An authorized individual (e.g., applicant or beneficiary, spouse, responsible household member or designated representative) is required to declare for the applicant/beneficiary and spouse whether or not they possess annuities. If the applicant/beneficiary or spouse possesses annuities, documentation must be submitted demonstrating that the annuities qualify to be disregarded as a countable or transferred asset. This documentation is required upon initial application as well as upon annual eligibility review. Failure to provide required documentation within the necessary timeframe will result in loss of coverage for LTCS and potentially eligibility termination.

Requirements for an annuity to be qualified include:

- Names the Department as a remainder beneficiary in the first position, or in a position behind the spouse and dependent child;

AN EQUAL OPPORTUNITY AGENCY

- Is actuarially sound as determined in accordance with actuarial publications of the Office of the Chief Actuary of the Social Security Administration;
- Is irrevocable and non-assignable;
- Makes equal payments throughout the term of the contract and does not defer payments or allow balloon payments; and
- Meets other requirements detailed in Hawaii Administrative Rules §17-1721-53.

Ongoing Medicaid Beneficiaries:

One month prior to the annual eligibility review, each Medicaid LTCS beneficiary will be mailed forms to be carefully completed, including one for the disclosure of annuities (DHS 8003). The DHS 8003 has multiple questions, and each question must be answered. Please assure that the beneficiary, spouse, responsible household member or designated representative signs the form.

New Medicaid Applicants:

Individuals applying for LTCS will be required to submit the required annuity information by completing the DHS 1100 Medical Assistance Application form (revised 12/11) or by completing a DHS 8003 if using an earlier version of the DHS 1100. This information is required to be submitted to the eligibility worker. Incomplete, untimely, erroneous and missing forms will result in a request for additional information. Failure to provide this information to the eligibility worker by the due date may result in determination of ineligibility. Please assure that the applicant, spouse, responsible household member or designated representative signs the form.

Who Can Sign Forms:

- The applicant/beneficiary, spouse, or other responsible household member; or
- A representative designated by the applicant/beneficiary, spouse, or other responsible household member.

Enclosed Forms:

For New Applicants:

- DHS 1100 - Medical Assistance Application (12/11)
- DHS 8003 - Reporting Requirements for Individuals Requesting/Receiving Coverage of Long-Term Care Services With Annuities - if applying using an earlier version of DHS 1100

For Ongoing Beneficiaries:

- DHS 8003 - Reporting Requirements for Individuals Requesting/Receiving Coverage of Long-Term Care Services With Annuities

Enclosures

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

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? Want (Free) interpreter? Yes: _____ No:______	

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 nursing facility and home and community-base services?** *(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 who wants medical assistance blind, disabled, or 65 years old or older?** *(You may receive income deductions and help with unpaid medical bills.)* Name__________

PLEASE GO TO THE NEXT PAGE AND ANSWER ALL QUESTIONS

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. Write the person's name and monthly gross amount **(before taxes and deductions—not take home pay)**. Attach copies of these documents if applying for nursing facility or home and community-based services. 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. Write the owner's name, bank or company name, and value. Attach copies of these documents if applying for nursing facility or home and community-based services. 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.			$
☐	☐	Other Assets (Please tell us)			

7. Please check YES or NO in the boxes below if you are applying for nursing facility or home and community-based services. If YES, please write information in the boxes. Please attach another paper if there are more information.

(You may be asked to provide additional information to help us process your application.)

YES NO

☐ ☐ **A. Did you and/or your spouse sell, trade or give away money, property, other resources, or assets in the past 5 years?**

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

YES NO

☐ ☐ **B. Do you and/or your spouse own any annuities?** *(You may be asked to complete more forms.)*

Owner's Name	Issuance Date	Annuity Company Name and Address

☐ ☐ **C. Do you and/or your spouse have a promissory note, loan, or mortgage?** *(Attach document copies.)*

	Owner's Name	Transaction Date	Original Amount	Balance Owed
Promissory Note			$	$
Loan			$	$
Mortgage			$	$

☐ ☐ **D. Do you and/or your spouse own a home?**

Owner's Name	Home Address	Equity Value
		$

☐ ☐ **E. Did you and/or your spouse buy a life estate interest in a home property of another?** *(Attach document copies.)*

Owner's Name	Transaction Date	Life Estate Interest Property Address	Amount Paid
			$
			$

☐ ☐ **F. Did you and/or your spouse pay an entrance fee to enter a Continuing Care Retirement Community (CCRC) or Life Care Community (LCC)?** *(Attach document copies.)*

Owner's Name	Transaction Date	CCRC/LCC Name and Address	Amount Paid
			$
			$

PLEASE GO TO THE NEXT PAGE AND ANSWER ALL QUESTIONS

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 number 3 who wants medical assistance have private health insurance, dental insurance, vision insurance, long-term care insurance, Medicare, TRICARE, VA benefits, other health insurance or prescription drug coverage?** *(Other insurance may help pay medical, dental, vision, or drug bills.)*

Person Covered	Insurance Name and Type	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. Does anyone have unpaid medical bills 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 § 346-43.5 or other criminal laws. 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 'o Med-QUEST i kekahi kanaka unuhi 'ōlelo a i 'ole i kekahi kanaka "sign language." 'Ae, makemake au i kekahi kanaka unuhi 'ōlelo.	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 ນາຍພາສາມືກ 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
☐	'E lava he'e Med-QUEST 'o 'omai e kau fakatonulea 'o tatau pe kihe lea moe faka'ilonga lea 'aki e nima. 'Io 'oku 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

What is Medicaid?
Medicaid is a program for persons who need medical assistance. QUEST, QUEST-ACE and QUEST-Net are programs for children and adults who are younger than 65 years of age, who are not blind or disabled. The QExA program is for children and adults who are blind or disabled, or adults who are age 65 years of age or older.

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 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.

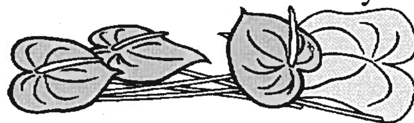
Do I enroll in a health plan if my application is approved for the QUEST program?
Yes. If you receive a letter from Med-QUEST that your application is approved for QUEST, you must enroll in a health plan within 10 days. You can choose from several health plans by calling our Customer Service Section 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. Medicaid can pay for some medical services for persons who are not citizens.

Will enrolling in a medical assistance program 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 is the DD/ID program?
The Developmental Disabilities/Intellectually Disabled program provides support services to persons who are developmentally or intellectually disabled so they 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 www.hawaii.gov/health/eoa/SAGEP.html

Executive Office on Aging
Dedicated to the well-being of older adults and their caregivers. 586-0100 (Oahu), 974-4000 (Hawaii), 274-3141 (Kauai), 984-2400 (Maui), 1-800-468-4644 (Molokai), or www.hawaii.gov/health/eoa/index.html.

Common Questions and Answers

Pregnant Women

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 DHS 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.

Children

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 (DHS 1149). Telephone numbers are listed on the last page of the application. You can also download the form at www.med-quest.us/mqdforms.html. After the doctor completes the form, bring it to Med-QUEST and they will review your application.

Aged, Blind, or Disabled Individuals

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).

Important Resources

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).

YOU MAY TEAR OFF AND KEEP

RIGHTS AND RESPONSIBILITIES *(YOU MAY TEAR OFF AND KEEP)*

WHAT I HAVE THE RIGHT TO EXPECT FROM THE DEPARTMENT:

RIGHT TO CONFIDENTIALITY: The Department will not 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 can call the Department of Human Services, Civil Rights Compliance Unit, at (808) 586-4955 or send a letter immediately to their office at DHS/PCRCU, P.O. Box 339, Honolulu, HI 96809-0339 or write to the U.S. Department of Health and Human Services (US DHHS), 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 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 of 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 will be sent a certificate of medical coverage when my medical assistance coverage ends. I can get a duplicate copy of the certificate up to 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: Social Security Numbers (SSNs) are used to verify the income and assets of persons who are applying for medical assistance to determine if they are eligible. I am required to provide SSNs for all persons who are applying for medical assistance for whom I am legally responsible (42 USC 1320b-7; 42 CFR 435.910(a)). 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 must certify that they 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, Republic of the Marshall Islands, or Republic of Palau, or authorized by law to receive assistance. I must provide proof of immigration status unless I am not applying for medical assistance, or am applying only for emergency medical services. (42 CFR 435.406)

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.

INCOME, ASSETS AND OTHER PROPERTIES: I must give the Department information about all income, assets or properties that are owned by my household unless I am only applying for medical assistance for my children or as a pregnant woman. My income, assets, and other properties will be used to determine my eligibility. If I get rid of any income, asset or property for less money than the fair market value, it may affect my eligibility for long term care services.

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; assets, 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, nursing facility, 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 631374 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 Place, 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

REPORTING REQUIREMENTS FOR INDIVIDUALS REQUESTING/RECEIVING COVERAGE OF LONG-TERM CARE SERVICES WITH ANNUITIES

The Deficit Reduction Act of 2005 under Sections 1917(c)(1), 1917(e)(1) and (2), and 1917(c)(1)(F) and (G) of the Social Security Act requires states to ensure that all individuals requesting and /or receiving coverage of Long-Term Care services must:

1) Disclose any interest they or their community spouse may have in annuities when applying for and at each subsequent annual redetermination.

2) Agree to name the State as remainder beneficiary for any interest they or their community spouse have in the annuity.

3) Agree to allow their Annuity Issuer to provide a copy of the Annuity and report all changes and amendments to the State in order to allow the State to determine whether the purchase of the annuities and/or any transactions are required to be considered as transfers for less than fair market value.

Failure to provide information regarding annuities owned by you or your spouse may result in the denial or termination of your eligibility for Long-Term Care services or the determination of the annuity as a countable resource. Failure to report required information may be subject to civil and/or criminal liability.

PART I (To be completed by DHS)

1. ____
Client Name (Last, First, MI) Date of Birth HAWI Case No. Client ID.

2. Long-Term Care Services are being provided:
☐ under Home & Community Based Services ☐ in a Nursing Facility

____

____
Admission Date to NF OR Start Date of HCBS

3. Marital Status: ☐ Single ☐ Divorced ☐ Widowed ☐ Married

PART II (To be completed by Applicant/Recipient, Spouse, Responsible Household Member or Designated Representative)

1. ____
If Married, Spouse's Name (Last, First, MI) Date of Birth Soc. Sec. No.

____
Mailing Address of Spouse City State Zip Code

2. Do you or your spouse own an annuity(ies) purchased prior to 02/08/06?
☐ NO ☐ YES If YES, provide the following information on the annuity(ies).

Annuity Owner(s)	Name and Address of Issuing Company	Policy No.	Purchase Date
a.			
b.			
c.			

Part II Continued from Page 1:

3. Do you or your spouse own an annuity(ies) purchased on or after 02/08/06?

☐ NO ☐ YES If YES, provide the following information for the annuity(ies) purchased.

Annuity Owner(s)	Name and Address of Issuing Company	Policy No.	Purchase Date
a.			
b.			
c.			

4. Were changes made to your annuity(ies) after initial purchase regardless of when they were purchased? ☐ NO ☐ YES If YES, provide the following:

A. Information regarding the transactions or changes that were made.
(Changes are not limited to the following transactions listed below.)

- ☐ Changes to the course of payment to be made by the annuity;
- ☐ Changes to the treatment of income or principal of the annuity such as additions of principal,
- ☐ Elective withdrawals or requests to change the distribution of the annuity; or
- ☐ Election to annuitize the contract.

B. Information for the transactions or changes made.

Annuity Owner(s)	Name & Address of Issuing Company	Policy No.	Type & Date of Change
a.			
b.			
c.			

PART III (To be completed by Applicant/Recipient, Spouse, Responsible Household Member or Designated Representative)

I CERTIFY THAT THE INFORMATION PROVIDED ON THIS FORM IS TRUE TO THE BEST OF MY KNOWLEDGE.

Print Name Signature Date Signed

Mailing Address City State Zip Code

Relationship to Applicant/Recipient Telephone No.