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State/Territory Name: Hawaii

State Plan Amendment (SPA) #: 13-0007 MM7

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
San Francisco Regional Office
90 Seventh Street, Suite 5-300 (5W)
San Francisco, CA 94103-6706

DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS

November 18, 2015

Dr. Judy Mohr Peterson
Med-QUEST Division Administrator
MQD/Admin
P.O. Box 700190
Kapolei, HI 96709-0190

Dear Dr. Peterson,

Enclosed is an approved copy of Hawaii's State Plan Amendment (SPA) 13-0007-MM7, which was submitted to my office on July 9, 2013. This SPA proposes to implement presumptive eligibility conducted by hospitals in the Medicaid state plan in accordance with the Affordable Care Act. The approval of this SPA is effective January 1, 2014.

Attached are copies of the State Plan pages to be incorporated into Hawaii's approved State Plan:

- S21, page 1-3
- Hospital PE Application
- Hospital PE Training Materials

Please note that there is also a companion letter included in this approval package. This companion letter specifies the anticipated implementation date of Hawaii's hospital-based presumptive eligibility program.

If you have any questions, please contact Christy Bonstelle at (415) 744-3522 or christy.bonstelle@cms.hhs.gov.

Sincerely,

/s/

Henrietta Sam-Louise
Acting Associate Regional Administrator
Division of Medicaid & Children's Health Operations

Cc: Tom Duran, CMS Pacific Area Representative
Edie Mayeshiro, Med-QUEST Program and Policy Development Office
Aileen Befitel, Med-QUEST Program and Policy Development Office

DEPARTMENT OF HEALTH & HUMAN SERVICES
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November 18, 2015

Dr. Judy Mohr Peterson
Med-QUEST Division Administrator
MQD/Admin
P.O. Box 700190
Kapolei, HI 96709-0190

Dear Dr. Peterson,

This letter is being sent as a companion to our approval of Hawaii's State Plan Amendment (SPA) 13-0007-MM7, which proposes to implement presumptive eligibility conducted by hospitals in the Medicaid state plan in accordance with the Affordable Care Act. This amendment was submitted on July 9, 2013 and has an effective date of January 1, 2014.

Section 1902(a) of the Social Security Act (the Act) requires that states have a state plan for medical assistance that meets certain Federal requirements that set out a framework for the state program. Implementing regulations at 42 CFR 430.10 require that the state plan be a comprehensive written statement describing the nature and scope of the state's Medicaid Program and that it contain all information necessary for the Centers for Medicare & Medicaid Services (CMS) to determine whether the plan can be approved to serve as the basis for Federal financial participation (FFP) in the state program. While the SPA is approvable, CMS' analysis determined that additional changes related to the state's implementation of the hospital presumptive eligibility provision are needed in the Hawaii Medicaid state plan.

As set forth in Section 1902(a)(47)(B) of the Social Security Act, states must provide a program for hospitals that choose to provide hospital presumptive eligibility determinations, effective January 1, 2014, as codified in the Section 2202 of the Affordable Care Act. Hawaii has provided sufficient SPA pages and supporting materials in the HI-13-0007-MM7 submission to show that it has policies in place and can begin to train hospitals as qualified entities, allowing CMS to approve this SPA. CMS acknowledges that Hawaii plans to start training hospitals in November 2015. Further, the state expects to begin accepting hospital PE determinations from qualified hospitals and allowing hospital PE determinations on or before December 1, 2015, so we are giving the state time to come into compliance with its approved state plan, which has an effective date of January 1, 2014.

Within 30 days of this letter, please reply to CMS to acknowledge receipt and provide an update on the state's training and implementation efforts. If you have any questions, please contact Christy Bonstelle at (415) 744-3522 or christy.bonstelle@cms.hhs.gov.

Sincerely,

/s/

Henrietta Sam-Louise
Acting Associate Regional Administrator
Division of Medicaid & Children's Health Operations

cc: Tom Duran, CMS Pacific Area Representative
Edie Mayeshiro, Med-QUEST Program and Policy Development Office
Aileen Befitel, Med-QUEST Program and Policy Development Office

Medicaid State Plan Eligibility: Summary Page (CMS 179)

State/Territory name: **Hawaii**

Transmittal Number:

Please enter the Transmittal Number (TN) in the format ST-YY-0000 where ST= the state abbreviation, YY = the last two digits of the submission year, and 0000 = a four digit number with leading zeros. The dashes must also be entered.

HI-13-0007

Proposed Effective Date

01/01/2014 *(mm/dd/yyyy)*

Federal Statute/Regulation Citation

42 C.F.R. 435.4, 435.110, 435.116, 435.118, 435.119, 435.150, 435.218, 435.220, 435.214, 435.226, 435.227, 4

Federal Budget Impact

	Federal Fiscal Year	Amount
First Year	2014	$ 85392536.00
Second Year	2015	$ 119936664.00

Subject of Amendment

The proposed amendments to the State Plan would implement provisions of the Patient Protection and Affordable Care Act of 2010 and the Health Care and Education Reconciliation Act of 2010. The proposed amendments implements the following: 1) New Medicaid eligibility groups; 2) Establishes financial methodologies for determining Medicaid eligibility based on modified adjust gross income (MAGI); 3) Establish simplified and date-driven renewal polices for individuals who eligibility is based on MAGI; 4) Simplifies residency, citizenship and immigration status; and 5) Allows presumptive eligibility conducted by hospitals for certain Medicaid eligibility groups.

Note: The Federal Budget Impact, Federal Statute/Regulation Citation, and the Subject of Amendment fields included on this CMS-179 form is combined information for SPAs 13-0007MM1 to 13-0007MM7.

Governor's Office Review

- ○ **Governor's office reported no comment**
- ○ **Comments of Governor's office received**
  Describe:
- ○ **No reply received within 45 days of submittal**
- ◉ **Other, as specified**
  Describe:
  As approved by the Governor

Signature of State Agency Official

Submitted By: **Aileen Befitel**

Last Revision Date: **Nov 9, 2015**

Medicaid Eligibility

State Name: Hawaii

OMB Control Number: 0938-1148

Transmittal Number: 13 - 07 - 0000

Expiration date: 10/31/2014

Presumptive Eligibility by Hospitals S21

42 CFR 435.1110

One or more qualified hospitals are determining presumptive eligibility under 42 CFR 435.1110, and the state is providing Medicaid coverage for individuals determined presumptively eligible under this provision.

(•) Yes ( ) No

☑ The state attests that presumptive eligibility by hospitals is administered in accordance with the following provisions:

■ A qualified hospital is a hospital that:

■ Participates as a provider under the Medicaid state plan or a Medicaid 1115 Demonstration, notifies the Medicaid agency of its election to make presumptive eligibility determinations and agrees to make presumptive eligibility determinations consistent with state policies and procedures.

■ Has not been disqualified by the Medicaid agency for failure to make presumptive eligibility determinations in accordance with applicable state policies and procedures or for failure to meet any standards that may have been established by the Medicaid agency.

Assists individuals in completing and submitting the full application and understanding any documentation requirements.

(•) Yes ( ) No

■ The eligibility groups or populations for which hospitals determine eligibility presumptively are:

■ Pregnant Women

■ Infants and Children under Age 19

■ Parents and Other Caretaker Relatives

■ Adult Group, if covered by the state

■ Individuals above 133% FPL under Age 65, if covered by the state

■ Individuals Eligible for Family Planning Services, if covered by the state

■ Former Foster Care Children

■ Certain Individuals Needing Treatment for Breast or Cervical Cancer, if covered by the state

☐ Other Family/Adult groups:

☐ Eligibility groups for individuals age 65 and over

☐ Eligibility groups for individuals who are blind

☐ Eligibility groups for individuals with disabilities

☐ Other Medicaid state plan eligibility groups

☐ Demonstration populations covered under section 1115

Medicaid Eligibility

The state establishes standards for qualified hospitals making presumptive eligibility determinations.

(•) Yes ( ) No

Select one or both:

[☒] The state has standards that relate to the proportion of individuals determined presumptively eligible who submit a regular application, as described at 42 CFR 435.907, before the end of the presumptive eligibility period.

Description of standards:

1. An 85% accuracy rate for correctly determined applications for HPE. This will be determined analyzing the HPE applications submitted by the hospital and evaluated for accuracy by EB staff;
2. 90% of individuals are offered help from hospital PE staff to complete the full Medicaid application;
3. 90% of hospital PE applicants will either submit a DHS 1100 application or an attestation sheets (completed by hospital staff for individuals who did not want to apply for regular Medicaid); and
4. 90% of hospital PE application packets shall be submitted timely (within 5 days from submission of HPE application) by the participating hospital to Med-QUEST Eligibility Branch.

[ ] The state has standards that relate to the proportion of individuals who are determined eligible for Medicaid based on the submission of an application before the end of the presumptive eligibility period.

[■] The presumptive period begins on the date the determination is made.

[■] The end date of the presumptive period is the earlier of:

The date the eligibility determination for regular Medicaid is made, if an application for Medicaid is filed by the last day of the month following the month in which the determination of presumptive eligibility is made; or

The last day of the month following the month in which the determination of presumptive eligibility is made, if no application for Medicaid is filed by that date.

[■] Periods of presumptive eligibility are limited as follows:

(•) No more than one period within a calendar year.

( ) No more than one period within two calendar years.

( ) No more than one period within a twelve-month period, starting with the effective date of the initial presumptive eligibility period.

( ) Other reasonable limitation:

The state requires that a written application be signed by the applicant, parent or representative, as appropriate.

(•) Yes ( ) No

( ) The state uses a single application form for Medicaid and presumptive eligibility, approved by CMS.

(•) The state uses a separate application form for presumptive eligibility, approved by CMS. A copy of the application form is included.

An attachment is submitted.

Medicaid Eligibility

■ The presumptive eligibility determination is based on the following factors:

■ The individual's categorical or non-financial eligibility for the group for which the individual's presumptive eligibility is being determined (e.g., based on age, pregnancy status, status as a parent/caretaker relative, disability, or other requirements specified in the Medicaid state plan or a Medicaid 1115 demonstration for that group)

■ Household income must not exceed the applicable income standard for the group for which the individual's presumptive eligibility is being determined, if an income standard is applicable for this group.

☒ State residency

☒ Citizenship, status as a national, or satisfactory immigration status

☑ The state assures that it has communicated the requirements for qualified hospitals, and has provided adequate training to the hospitals. A copy of the training materials has been included.

An attachment is submitted.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20140415

State of Hawaii
Department of Human Services
Med-QUEST Division

Please use this form to apply if you are a patient of the hospital, a patient's family member, or a community member.

Application for Presumptive Eligibility for Medicaid

Use this form to find out quickly if you qualify for presumptive eligibility for Medicaid. Presumptive eligibility offers you and your family immediate access to health care while you apply for regular Medicaid or other health coverage.

To find out if you qualify for regular Medicaid or other health coverage, you must complete the Hawaii Application for Health Coverage & Help Paying Costs. While you wait to learn if you qualify for regular Medicaid or other health coverage, you can get your health services through presumptive eligibility for Medicaid.

You can also apply for regular Medicaid and other health coverage online at mybenefit.hawaii.gov, via telephone, in person, or by mail.

Who can qualify for presumptive eligibility for Medicaid?

You can qualify for presumptive eligibility for Medicaid if you meet all of these rules:

- Your income is below the applicable monthly limit.
- You are a U.S. citizen, U.S. national, or eligible non-citizen.
- You do not already have Medicaid.
- You have not had presumptive eligibility for Medicaid in the past 12 months.
- If you are pregnant, you have not had presumptive eligibility for Medicaid during this pregnancy.
- You are in one of the groups that qualifies for presumptive eligibility for Medicaid:
  - Children under 19 years of age
  - Parents and caretaker relatives
  - Pregnant women
  - Other adults age 19 – 64 years
  - People under age 26 who were in foster care

How can I get help with this application?

Ask your hospital representative or call us toll free at 1-800-316-8005. If you need help in a language other than English, call toll free at 1-800-316-8005 and tell the customer services representative the language you need. We will get you help at no cost to you. TTY/TTD users call toll free at 1-800-603-1201.

This is an important letter from the Department of Human Services. Please call the phone number located on the letter. When you call, you will be asked what language you speak and your call will be put on hold for an interpreter. You can also call 1-800-316-8005 for all DHS services.	**English** 
這是一封從人類服務部門發出的重要信件。請撥打信上的電話號碼。當你打電話時，你將會被詢問你講什麼語言，您的通話將被擱置直到接通翻譯服務。其他人類服務部門的服務, 您可以致電到 1-800-316-8005.	**Cantonese** 
Ei taropwe mi auchchea seni ewe putain tumwunun aramas (Department of Human Services). Kose mwochen kokkori na nampan foon won na taropwe. Nupwen omw kokko, repwe eisinuk menni kkapas ke sine pwe repwe kkutta ngonuk emon choon chiaku. Ka pwan tongeni kokkori 1-800-316-8005 ren meinisin aninnis seni DHS.	**Chuukese** 
Ceci est une lettre importante du Department of Human Services (DHS). S'il vous plaît, faire un appel téléphonique au numéro de téléphone situé sur la lettre. Lorsque vous téléphonez, quelqu'un va vous demander quelle langue vous parlez, et votre appel sera mis en attente pour un interprète. Vous pouvez aussi téléphoner 1-800-316-8005 pour tous les services de DHS.	**French** 
Dies ist eon wichtiger Brief von der Abteilung Menschlicher Dienste (DHS). Bitte rufen Sie die Telefonnummer, die auf dem Brief gefunden wurde. Wenn Sie rufen, werden Sie gefragt werden, welche Sprache Sie sprechen, und Ihr Anruf wird auf Wartestellung für einen Dolmetscher geschaltet werden. Sie können 1-800-316-8005 für alle DHS Dienste auch rufen.	**German** 
He leka ko'iko'i keia mai ka 'Oihana Lawelawe Kanaka (Department of Human Services). E kelepona mai i ka helu kelepona ma luna o ka leka. Ke kelepona 'oe, e ninau 'ia ana 'oe he aha kau 'olelo 'oiwi a laila e kali 'oe a loa'a ke kanaka mahele 'olelo. Hiki pu ia 'oe ke kelepona i 1-800-316-8005 no na lawelawe a pau a ka 'Oihana Lawelawe Kanaka (DHS).	**Hawaiian** 
Daytoy ket importante nga surat nga naggapu iti Department of Human Services. Pangaasi nga tawagan yo iti numero iti telepono nga nakakabil iti daytoy nga surat. Nu umawag kayo, saludsuden da nu anya iti panagsasao yo ket urayen yo nga maiyallatiw iti tawag yo iti intepreter. Mabalin kayo nga umawayg iti 1-800-316-8005 para kadagiti amin nga serbisyo iti DHS.	**Ilocano** 
ハワイ州人道的奉仕局からの大切なお知らせです。 この紙面に書かれている番号にお電話ください。 電話を された時に、貴方がどの言語を話されているかを聞かれます、 通訳に接続 されるまでしばらくお待ち ください。 ＤＨＳのどのサービスにも、 この電話番号 1-800-316-8005 で対応いたします.	**Japanese** 
인간 서비스 부서에서 보내는 중요한 편지 입니다. 이편지에 기재된 전화번호로 전화를 하시요. 당신이 전화를 할때 당신이 사용하는 언어를 물을것이고 그언어의 통역인에게 연결할것 입니다. 당신은 모든 인간 서비스 부서(디에이치에스)에 도움을 받기 위해서1-800-316-8005 로 전화 할수 있읍니다	**Korean** 
这是一封从人类服务部门发出的重要信件。请拨打信上的电话号码。当你打电话时，你将会被询问你讲什 么语言，您的通话将被搁置直到接通翻译服务。其他人类服务部门的服务, 您可以致电到 1-800-316-8005。	**Mandarin** 
Juon in kojela im elap an aurok im ej itok jen ra eo an department of human services. Jouij im call e nomba in im ej bed ilo pepa in ak letta in. Ne koj call, renej kajitok ibbem kin kain kajin eo am im elikin am ba renej ba kwon kottar bwe ren lewoj juon am ri okok. Komaron call 1-800-316-8005 non aolepen ra ko kajojo ilo DHS services.	**Marshallese** 
O se fa'asilasilaga ta'ua lenei mai le Ofisa o le Human Services. Fa'amolemole, vala'au mai i le numera lea o lo'o i luga o lenei tusi. A e vala'au mai, o le a fesili atu po'o le a le gagana e te mo'omia, ona tu'u sa'o lea o lau telefoni i se tagata e mafai ona fesoasoani ia oe. E mafai fo'i ona e vala'au i le number 1-800-316-8005 mo nisi 'au'aunaga mai lenei Ofisa."	**Samoan** 
Ésta es una carta importante de la Sección de Servicios Humanos (DHS). Por favor llame el número de teléfono localizado en la carta. Cuando usted llama, usted se preguntará qué idioma usted habla y su llamada se pondrá en espera para un intérprete. Usted también puede llamar 1-800-316-8005 para todos los servicios de DHS.	**Spanish** 
Ito ay mahalaga na sulat na galling sa Department of Human Services. Mangyaring tawagan ang numero na nakalagay sa sulat na ito. Kung kayo ay tatawag , tatanungin kung ano ang iyong wika at hintayin ninyo hanggat may sumagot na tagasalin. Pwede ninyong tumawag sa 1-800-316-8005 para sa lahat ng serbisio sa	**Tagalog** 
Ko e tohi mahu'inga eni mei he Potungaue Ngaue Ma'ae Kakai. Kataki 'o telefoni ki he fika 'oku ha 'i he tohi ni. 'E fehu'i atu pe ko e ha e fa'ahinga lea 'oku ke lea'aki 'i he taimi te ke ta mai ai pea tnitokoe ke tali kae 'oua kuo ma'u ha toko taha fakatonu lea. Te ke lava 'o ta ki he ki he ngaahi tokoni kotoa 'a e DHS.	**Tongan** 
Đây là lá thơ quang trọng từ các Bộ Phục Vụ Nhân Dân (DHS). Làm ơn gọi xố điện thoại nằm trên lá thơ. Khi bạn gọi, bạn sẻ được hỏi ngôn ngữ nào bạn nói và cú điện thoại của bạn sẻ chờ người thông dịch. Đồng thời bạn củng có thể gọi số 1-800-316-8005 cho các phục vụ DHS.	**Vietnamese Việt Nam**
Kini importante nga sulat gikan sa Department of Human Services (DHS). Palihug tawagi ang numero sa maong telepono nga nahimutang sa sulat. Sa imong pagtawag, ikaw pangutan-on kun unsa ang imong pinulongan ug ang imong tawag ilang ipahulat para sa usa ka taghubad sa pinulongan. Mahimo usab nga imong tawagan ang 1-800-316-8005 para sa tanang mga serbisyo sa DHS.	**Visayan** 

STEP 1 Tell us about yourself.

We need one adult in the family to be the contact person for your application.

1. First Name | Middle name | Last name | Suffix

2. Home address (Leave blank if you don't have one.) | 3. Apartment or suite number

4. City | 5. State | 6. ZIP code | 7. County

8. Mailing address (if different from home address) | 9. Apartment or suite number

10. City | 11. State | 12. ZIP code | 13. County

14. Phone number
( )

15. Other phone number
( )

16. Do you want to get information about this application by email? ☐ Yes ☐ No

Email address: _____

17. What is your preferred spoken language (if not English)?

18. What is your preferred written language (if not English)

STEP 2 Tell us about your family.

List yourself and the members of your immediate family who live with you. Include your spouse, your children under the age of 19 years if they live with you and anyone you include on your tax return, even if they don't live with you.

Name *(first, middle, last)*	Date of birth (XX/XX/XXXX)	Relationship to you	Applying for presumptive eligibility for Medicaid? (Yes or No)	Already has Medicaid or other medical insurance? (Yes or No)	U.S. Citizen, U.S. National or eligible Non-citizen? (Yes or No)	Resident of Hawaii (Yes or No)	Social Security Number (SSN) (You don't have to provide this now, but it helps us determine eligibility for regular Medicaid faster)
				Answer for family members who are applying. If a person is not applying, you do not have to answer these questions for that person.			
(Same as above)		(Self)					

STEP 3 Other questions.

Answer these questions for yourself and your family members listed in Step 2. Your answers will make it easier to find out if you and any family member(s) qualify.

Is anyone pregnant who is applying for presumptive eligibility for Medicaid? ☐ Yes ☐ No

If yes, who?_____ How many babies does she expect?_____

Is anyone who is applying for presumptive eligibility for Medicaid receiving Medicare or Social Security Income (SSI)? ☐ Yes ☐ No

If yes, who?_____

Is anyone who is applying for presumptive eligibility for Medicaid a parent or caretaker relative? ☐ Yes ☐ No
For example, a grandparent who is the main person taking care of a child.

If yes, who?_____

Was anyone who is applying for presumptive eligibility for Medicaid in foster care at age 18? ☐ Yes ☐ No

If yes, who? _____

STEP 4 Tell us about your family's income.

Write the total income before taxes are taken for all family members listed in Step 2.

- **Job income**: *For example, wages, salaries, and self-employment income.*

Amount $ How often? *(check one)* ☐ Weekly ☐ Biweekly ☐ Monthly ☐ Yearly

- **Other income** *For example, unemployment checks, alimony, or disability payments from the Social Security Administration ("SSDI"). Do **not** include Supplemental Security Income ("SSI payments") or any child support you receive.*

Amount $ How often? *(check one)* ☐ Weekly ☐ Biweekly ☐ Monthly ☐ Yearly

STEP 5 Read & sign this application.

- I'm signing this application under penalty of perjury which means I've provided true answers to all questions this form to the best of my knowledge. I know that I may be subject to penalties under state or federal law if I provide false or untrue information.
- I understand that under federal law, discrimination isn't permitted on the basis of race, color, national origin, sex, age, secual orientation, gender identity, or disability. I can file a compliant of discribmiation by visiting www.hhs.gov/ocr/office/file.
- The person who filled out Step 1 should sign this application.

Signature	Date (mm/dd/yyyy)

STEP 6 If you qualify for presumptive eligibility for Medicaid, what happens next?

- You will get a notice from the hospital saying you were approved.
- **You can start using your presumptive eligibility for Medicaid coverage right away** for Medicaid covered services such as doctor visits, hospital care, and some prescription drugs. You can go to any health care provider who accepts Medicaid starting the day you are approved. To start using your presumptive eligibility for Medicaid, use your approval notice from the hospital saying you are approved.
- **To see if you qualify for regular Medicaid or other health coverage,** the hospital will help you fill out the Hawaii Application for Health Coverage & Help Paying Costs, if you choose. You can also apply for regular Medicaid and other health coverage online at mybenefit.hawaii.gov, via telephone, in person, or by mail.
- **Your presumptive eligibility will end on the date your application for Medicaid is either approved or denied.** If you are denied, you will be referred to the Connector for other affordable insurance programs.
- **If you do not fill out and submit the Hawaii Application for Health Coverage & Help Paying Costs** to see if you qualify for regular Medicaid or other health coverage, your presumptive eligibility for Medicaid coverage will end on the last day of the month after the month you are approved.

  For example, if you qualified for presumptive eligibility for Medicaid in January, it will end on the last day of February.

STEP 7 If you do not qualify for presumptive eligibility for Medicaid, what happens next?

You will get a notice from the hospital saying you were not approved. You cannot appeal the hospital's decision. But you can still apply for regular Medicaid or other health coverage using the Hawaii Application for Health Coverage & Help Paying Costs.

Hospital Presumptive Eligibility in Hawaii

TN NO: 13-007-MM7 Approval Date November 18, 2015 Effective Date: January 1, 2014

Overview

- What is Hospital Presumptive Eligibility (HPE)?
- How hospitals can participate in HPE
- Hospital staff eligible to make HPE determinations
- Who is eligible and what are the HPE benefits?
- How the HPE Process works
- Contact information

ACA Coverage Changes

The Affordable Care Act (ACA) was signed into law in March 2010; it makes major changes to how people secure health coverage in the U.S. Coverage changes include:

- Medicaid and CHIP expansion and improvements
- Health insurance marketplaces for individuals and small businesses
- Private insurance market reforms

The New Vision for Medicaid and CHIP

- **Medicaid Coverage Expansion**
  - Covers adults 19-64 with incomes up to 133% FPL who are not eligible and enrolled in a mandatory group
- **Single, Streamlined Application**
  - Individuals can apply for Marketplace coverage and all insurance affordability programs (Medicaid, CHIP, premium tax credits) on one application
- **Simplified Eligibility and Enrollment Rules**
  - Modified Adjusted Gross Income (MAGI) is the new income methodology based on IRS-defined concepts of income and household to determine Medicaid and CHIP eligibility for children, pregnant women, parents and caretaker relatives, and adults 19-64
- **Modernized Eligibility Systems**
  - Increases use of automated rules engines to enable real-time eligibility determinations; individuals can apply for coverage online
- **Children's Coverage Improvements**
  - All children up to age 19 with family incomes up to 133% FPL are now Medicaid-eligible
- **Hospital Presumptive Eligibility**
  - Hospitals can now determine individuals to be presumptively eligible for Medicaid

HPE Overview

What Is Hospital Presumptive Eligibility (HPE)?

- As of January 1, 2014, hospitals can immediately determine Medicaid eligibility for certain individuals who are likely to be eligible.
- Eligibility under HPE is temporary but allows immediate access to coverage for eligible individuals.
- The policies and procedures for determining HPE may differ from the current policies and procedures for determining regular Medicaid assistance.

Terms and Definitions

- **Application Signature**: The application must be signed by an adult household member (age 18 or over) or by an authorized representative.
- **Application Submission**: Applications may be submitted in person, by mail, or by fax.
- **Certain Individuals Needing Treatment for Breast or Cervical Cancer**: An individual who has been screened by an authorized CDC approved facility and requires treatment for breast or cervical cancer or a precancerous condition of the breast or cervix.
- **Dependent Child**: A child from birth to age 19
- **Eligibility Determination**: An approval or denial of eligibility.
- **Family Size Using Modified Adjusted Gross Income (MAGI) Methodology**: Means the number of persons counted as members of an individual's household. When determining the family size of individuals who have a pregnant woman in their household, the pregnant woman is counted just as herself.

Terms and Definitions

- **Former Foster Care Child:** An individual who is 18 to 26 years of age, not eligible for any other Medicaid coverage group, and was covered under Medicaid and in foster care when they turned age 18 or out of foster care.

- **Modified Adjusted Gross Income (MAGI)**: The methodology used to determine financial eligibility.

- **Non-Applicant**: An individual who is not seeking an eligibility determination for himself or herself and is included in an applicant's or client's household to determine eligibility for such applicant or client.

- **Non-Filer**: Individuals who do not intend either to file taxes or to be claimed as a tax dependent.

Terms and Definitions

- **Parent/Caretaker Relative**: A relative of a dependent child by blood, adoption, or marriage with whom the child is living, who assumes primary responsibility for the child's care, and who is one of the following:

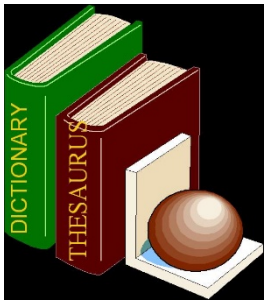
  - The child's father, mother, grandfather, grandmother, brother, sister, stepfather, stepmother, stepbrother, stepsister, uncle, aunt, first cousin, nephew, or niece;
  - The spouse of such parent or relative including same sex marriage, even after the marriage is terminated by death or divorce; or
  - Another relative of the child based on blood, adoption, or marriage; the domestic partner of the parent or caretaker relative; or an adult with whom the child is living and who assumes primary responsibility for the dependent child's care.

Terms and Definitions

- **Pregnant Woman Hospital Presumptive Eligibility**: Medical coverage for an individual eligible in the Pregnant Women group is limited to prenatal services that are provided on an outpatient basis. For coverage of full Medicaid benefits, a pregnant woman must apply for regular Medicaid assistance.

- **Tax Dependent**: An individual for whom another individual claims a deduction for a personal exemption for a taxable year.

- **Tax Filer**: Individuals who intend to file a federal tax return for the coverage year and who do not intend to be claimed as a tax dependent by another taxpayer.



How HPE Works to Get People Connected to Coverage and Care

- HPE improves individuals' access to Medicaid and necessary services by providing another channel to apply for medical coverage.
- Hospitals will be reimbursed for services provided during the PE period.
- HPE is not about short-term coverage; it provides individuals with an opportunity to get connected to longer-term coverage options.

How Hospitals Can Participate in HPE

How Hospitals Can Participate in HPE

- Hospital participation in HPE is optional, but States must provide a mechanism for a hospital to become qualified to offer the HPE program.
- To make HPE determinations, a hospital must:
  - ❖ Participate in the Medicaid program;
  - ❖ Notify the State of its election to make HPE determinations by contacting the Program Administrator;
  - ❖ Designated staff must complete HPE training modules;
  - ❖ Agree to make HPE determinations consistent with policies and procedures of the State by signing an attestation form;
  - ❖ Maintain performance standards set by State; and
  - ❖ Have a signed Memorandum of Agreement (MOA) with the Department on file.

Hospital Staff Eligible to Make HPE Determinations

- Once a hospital is a qualified entity:
  - ❖ Any hospital employee who is properly trained and certified can make HPE determinations.
- Participating hospitals may not delegate HPE determinations to non-hospital staff:
  - ❖ Third party vendors or contractors may not make HPE determinations.
- Eligibility determinations will be based on MAGI non-filer rules:
  - ❖ The household's size will be determined by counting the individual plus their spouse and natural, adopted and step-children under age 19, or up to age 26 if a full time student, who are living together in the same household and who are not expected to be claimed by another tax-filer.

How Will Hospitals Be Trained?

The Department will use a Medicaid training module consisting of:

- This powerpoint presentation, which provides an overview of the Hospital Presumptive Eligibility (HPE) program and application for full Medicaid requirements for participating hospital staff;
- HPE Workshop conducted by assigned DHS staff.

The Department will conduct additional training(s) to address hospital deficiencies after initial implementation of HPE :

- Department staff will monitor hospital ability to meet performance standards;
- Additional training will focus on areas that need improvement or additional guidance.

Workshop and Training will include:

- Overview of HPE and regular Medicaid programs;
- Roles and responsibilities for the Hospital and Eligibility branch;
- Explanation of performance standards and requirements;
- Eligibility requirements for HPE, Children, Pregnant Women, Parent Caretaker Relatives, Adults, Former Foster Care Children and Certain Individuals Needing Treatment for Breast or Cervical Cancer * coverage groups;
- How to complete the HPE application form, DHS 1100, and other applicable Medicaid forms;
- The HPE eligibility determination process using MAGI non-filer rules for household composition and income eligibility;
- How to prepare and submit the HPE packet to EB for processing;
- All bases of coordination between hospital and Med-QUEST required to process for HPE (assigned staff, contact numbers, etc).

* Hospital must be designated as a CDC approved screening site for BCCEDP

Process for Staff Training and Certification

- Hospitals must select staff for training and certification and provide list of names for Department;
- Hospitals must coordinate with Med-QUEST to arrange for training of staff;
- Selected staff must attend Department approved HPE/Medicaid Workshop and Training;
- Staff must complete Department approved workshop and training and become certified in order to make HPE determinations;
- Staff must sign agreement to comply with all MOA requirements for participation in the HPE program;
- Certified hospital staff will be able to determine eligibility and issue notice of approval for HPE coverage to eligible individuals.

HPE Accuracy and Performance Standards

Hospitals shall be required to maintain the following performance standards to participate in the HPE program:

1) An 85% accuracy rate for correctly determined applications for HPE. This will be determined analyzing the HPE applications submitted by the hospital and evaluated for accuracy by EB staff;
2) 90% of individuals are offered help from hospital PE staff to complete the full Medicaid application;
3) 90% of hospital PE applicants will either submit a DHS 1100 application or an attestation sheets (completed by hospital staff for individuals who did not want to apply for regular Medicaid); and
4) 90% of hospital PE application packets shall be submitted timely (within 5 days from submission of HPE application) by the participating hospital to Med-QUEST Eligibility Branch.

HPE Performance Standards

- The Department shall initially authorize a “Phase in “ period to help hospitals reach required performance standards without penalty for initial 6-12 months of HPE program implementation.

- The Department shall analyze initial performance standards and focus training on areas that are not meeting requirements. Hospitals not meeting HPE program requirements will complete additional training in deficient areas. If still unable to meet standards after additional training, hospital will be subject to disqualification from the HPE program.

- The Department has the authority to terminate hospital participation in the HPE program for failure to meet Department policies and established standards, including failure to participate in additional training when deficiencies are identified.

Who is Eligible to Enroll in Medicaid through HPE? What are the Benefits?

Populations Eligible for Medicaid via HPE Determinations

- Individuals who fall into one of the following MAGI groups may be determined for HPE:

  Children, Pregnant Women, Parents and Caretaker relatives, Adults, Former Foster Care Children and Certain Individuals Certain Individuals Needing Treatment for Breast or Cervical Cancer who are:

  - Not currently receiving Medicaid benefits and have not had a PE period in the last 12 months or for the same pregnancy (for a pregnant woman);
  - A Hawaii resident; and
  - A U.S. citizen or qualified non-citizen who meets Medicaid citizenship status requirements.

Criteria for Determining HPE Eligibility

The current MAGI rules are used to determine the following:

- Household Size;
- Coverage Group; and
- Financial Eligibility.
- The Department will use non-filer MAGI rules when determining financial eligibility for the HPE program.

HPE Income Eligibility Chart

2015 Standards of Assistance

HH Size	Parents or Caretaker Relatives		Adults/ Children 6-19		Children 1 < 6		Pregnant Women/ Child < 1		SCHIP Children < 19	
	100%	105%*	133%	138%*	139%	144%*	191%	196%*	308%	313%*
1	$1,130	$1,186	$1,502	$1,502	$1,570	$1,626	$2,157	$2,157	$3,478	$3,535
2	$1,528	$1,528	$2,032	$2,032	$2,124	$2,200	$2,918	$2,918	$4,705	$4,782
3	$1,926	$1,926	$2,562	$2,562	$2,677	$2,774	$3,679	$3,679	$5,932	$6,028
4	$2,325	$2,325	$3,092	$3,092	$3,231	$3,347	$4,440	$4,440	$7,159	$7,275
5	$2,723	$2,723	$3,621	$3,621	$3,785	$3,921	$5,200	$5,200	$8,386	$8,522
6	$3,121	$3,121	$4,151	$4,151	$4,338	$4,494	$5,961	$5,961	$9,613	$9,769
7	$3,520	$3,520	$4,681	$4,681	$4,892	$5,068	$6,722	$6,722	$10,840	$11,015
8	$3,918	$3,918	$5,211	$5,211	$5,446	$5,642	$7,483	$7,483	$12,066	$12,262
9	$4,317	$4,317	$5,741	$5,741	$6,000	$6,215	$8,244	$8,244	$13,293	$13,509
10	$4,707	$4,707	$6,270	$6,270	$6,553	$6,789	$9,005	$9,005	$14,520	$14,756
Each Add'l Person	$399	$419	$530	$550	$554	$574	$761	$781	$1,227	$1,247

*** Maximum allowable income with 5% disregard applied to the income standard as applicable.**

Note: 1) Former Foster Care Children have no income limit;

2) Financial eligibility for Certain Individuals Needing Treatment For Breast or Cervical Cancer is not subject to Medicaid income limits.

Countable Income Includes:

- Wages, salaries, tips, etc. ;
- Taxable interest;
- Alimony;
- Business income;
- Capital gains;
- Unemployment benefits;
- Rental real estate, royalties, partnerships, S corporations, etc. ;
- Other taxable income.

***ASSETS ARE NOT COUNTED FOR THE MAGI ELIGIBILITY GROUPS**

Non-Tax Filer MAGI rules

Non-Tax filer MAGI rules will be used to determine financial eligibility for HPE applicants, regardless of their actual tax filing status. To determine household size, count the following household members:

a. Applicant (and if living with the applicant):
   - Spouse
   - Child(ren)* under age 19 years

b. If applicant is under age 19 (and if living with the applicant):
   - Spouse
   - Child(ren)* under age 19 years;
   - Parent(s)*
   - Sibling(s)* under age 19 years

*Includes natural or biological, adopted, or step (parent/child/sibling). For sibling, includes half- sibling.

Determination of Household size, Income and Coverage Group

1) Evan (age 29) is applying for coverage for himself, his pregnant wife, Keira (age 26), and their daughter, Lilly (age 3) who all live together. Evan states he earns $1800 per month from his job. Keira does not work. Although Evan and Keira intend to file jointly, MAGI non-filer rules are applied to determine eligibility for HPE .

2) Evan and Keira have daughter Lily, so are first determined for eligibility under the Parent/Caretaker Group. If not eligible in this group, would be considered under another applicable coverage group (i.e. Adults).

   Lilly is under age 6, therefore, she is determined for eligibility under the Childrens Group (Child 1<6).

Determination of Household size, Income and Coverage Group (Cont'd)

3) Using the HPE Income Eligibility chart:
   - Evan and Keira's income of $1,800 < $1,926 Parent/Caretaker Group standard for a household size of 3, therefore, they are eligible under this coverage group.
   - Lilly's income of $1,800 < $2,677 Children Group standard for a household size of 3, therefore she is eligible under this group.

4) Tax household composition, size and coverage groups for Evan, Keira, & Lilly are shown below:

HH	Evan	Keira	Lilly	Family Size	Income	Coverage Group
Evan	X	X	X	3	$1,800	Parent/Caretaker
Keira	X	X	X	3	$1,800	Parent/Caretaker
Lilly	X	X	X	3	$ 1,800	Children

What are the Benefits?

Individuals approved for presumptive eligibility receive the same Medicaid services as the group they are approved for under the Medicaid State Plan and 1115 Waiver as applicable. However, for individuals eligible in the Pregnant Women group, presumptive eligibility is limited to ambulatory prenatal care only.

Duration of Eligibility under HPE

- The HPE period begins with, and includes, the day on which the hospital makes the HPE determination.

- The HPE period ends on:
  - ❖ The day on which the eligibility site makes the eligibility determination for full Medicaid; or
  - ❖ The last day of the month following the month in which the hospital makes the HPE determination if the individual did not apply for Medicaid.

- The HPE period is limited to one in a 12 month period and/or once per pregnancy for a pregnant woman.

How The HPE Process Works

Hospital PE Application

- The HPE application is a short application form for individuals to apply for hospital presumptive eligibility. It requests minimal information such as:
  - ❖ Contact information
  - ❖ Household members
  - ❖ Total income for the household
- For individuals with no previous Medicaid ID number, a temporary ID number will be created using the hospital's provider ID + the last 4 digits of the individual's SSN until a Medicaid ID number is generated by Med-QUEST staff;
- Hospital shall log all HPE applications and send monthly data to Med-QUEST for monitoring purposes.

Verification of Eligibility Criteria

- Hospital Presumptive Eligibility determinations will be based on self-attestation of required information;
- Individual cannot be required to provide proof/documentation of any HPE eligibility criteria (e.g., can't require medical verification of pregnancy);
- Hospital/Department must accept self-attestation of income, citizenship/immigration status, State residency and household size.

The HPE Determination Process

At the individual's initial visit, trained hospital staff shall:

- Check for current Medicaid eligibility by contacting the Enrollment Call Center for applicable information (Medicaid status, Medicaid ID number, Health plan);
- If already a Medicaid recipient, refer applicant to appropriate health plan for assistance, not eligible for HPE;
- If not a Medicaid recipient, determine if individual meets HPE eligibility requirements for appropriate coverage group;
- Self-attestation of previous or current Medicaid eligibility shall be accepted during non-business hours;
- If HPE requirements are met, help the individual complete the HPE application form for HPE. If determined ineligible for HPE, explain benefits of "regular" Medicaid and offer to help applicant complete the DHS 1100, "Application for Health Coverage & Help Paying Costs" form for submission to Med-QUEST if interested in applying;

The HPE Determination Process (cont'd)

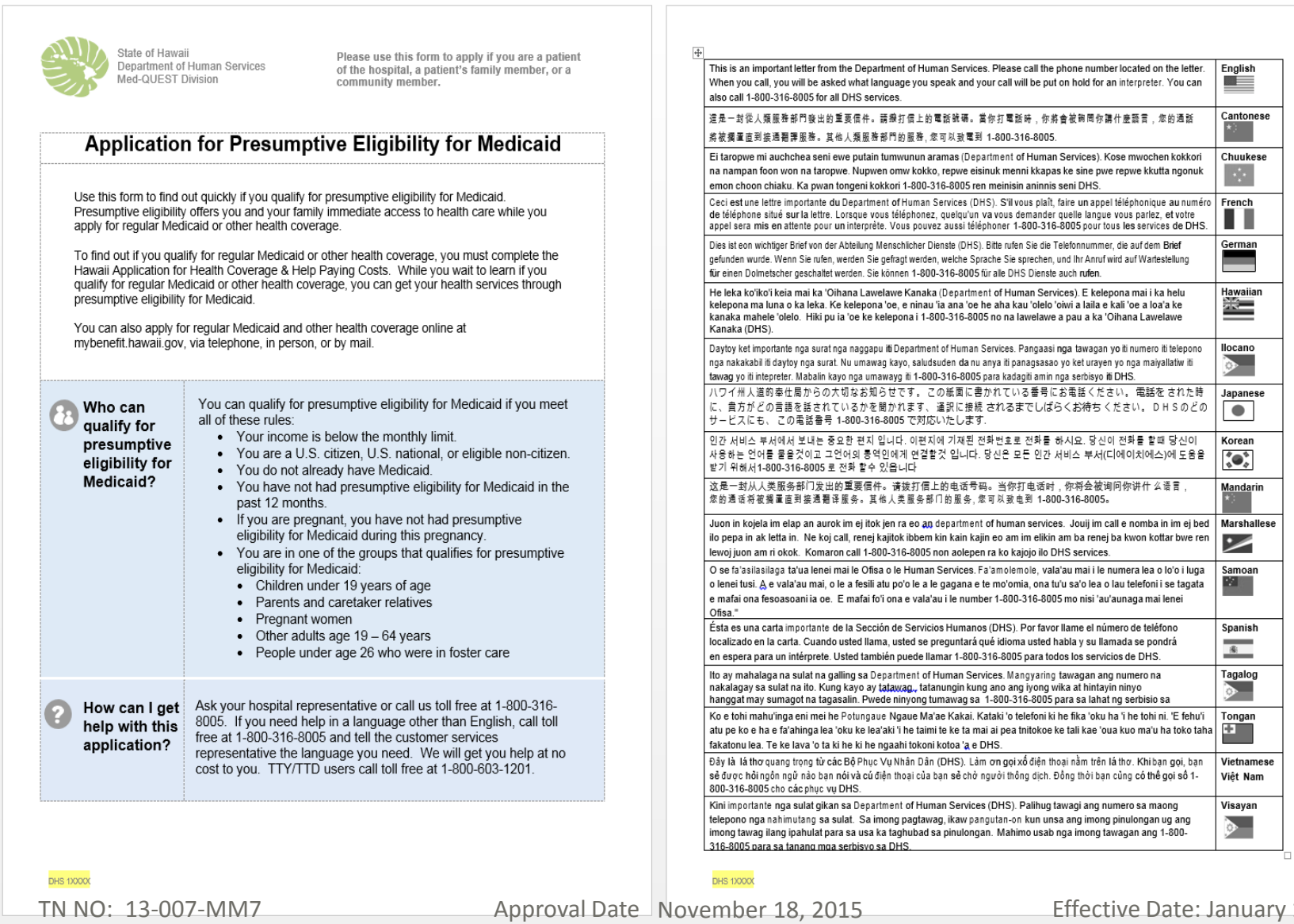
- Complete HPE eligibility determination and give applicant approval notice verifying applicant's HPE eligibility, coverage group and effective date of HPE coverage;
- Explain to applicant that the notice will serve as verification of eligibility for applicant;
- Offer assistance to applicant to apply for regular Medicaid by completing the DHS 1100 form.
- If applicant chooses not to apply for Medicaid, indicate this on the "Attestation sheet for DHS 1100" and sign in the field indicated on the bottom of the sheet.
- If applicant wants to apply for regular Medicaid, assist with application form and have HPE applicant sign and date the "Attestation sheet for DHS 1100"; and
- Submit with the HPE packet to the EB unit.

Create HPE packet to send to Med-QUEST

Upon completion of the HPE determination, hospital staff shall:

1) Create HPE packet to fax to appropriate EB office consisting of:
    - Completed and signed HPE packet cover sheet;
    - Completed HPE application
    - HPE decision notice;
    - Completed DHS 1100 if applicable; and
    - Completed Attestation sheet for DHS 1100
2) Record HPE application on hospital HPE log and date information is faxed to EB;
3) Fax complete packet to the appropriate Med-QUEST office within 5 days for HPMMIS input and determination of regular Medicaid; and
4) Keep hard copies of HPE packets for future reference.

Hospital PE Application



State of Hawaii
Department of Human Services
Med-QUEST Division

Please use this form to apply if you are a patient of the hospital, a patient's family member, or a community member.

Application for Presumptive Eligibility for Medicaid

Use this form to find out quickly if you qualify for presumptive eligibility for Medicaid. Presumptive eligibility offers you and your family immediate access to health care while you apply for regular Medicaid or other health coverage.

To find out if you qualify for regular Medicaid or other health coverage, you must complete the Hawaii Application for Health Coverage & Help Paying Costs. While you wait to learn if you qualify for regular Medicaid or other health coverage, you can get your health services through presumptive eligibility for Medicaid.

You can also apply for regular Medicaid and other health coverage online at mybenefit.hawaii.gov, via telephone, in person, or by mail.

Who can qualify for presumptive eligibility for Medicaid?

You can qualify for presumptive eligibility for Medicaid if you meet all of these rules:

- Your income is below the monthly limit.
- You are a U.S. citizen, U.S. national, or eligible non-citizen.
- You do not already have Medicaid.
- You have not had presumptive eligibility for Medicaid in the past 12 months.
- If you are pregnant, you have not had presumptive eligibility for Medicaid during this pregnancy.
- You are in one of the groups that qualifies for presumptive eligibility for Medicaid:
  - Children under 19 years of age
  - Parents and caretaker relatives
  - Pregnant women
  - Other adults age 19 – 64 years
  - People under age 26 who were in foster care

How can I get help with this application?

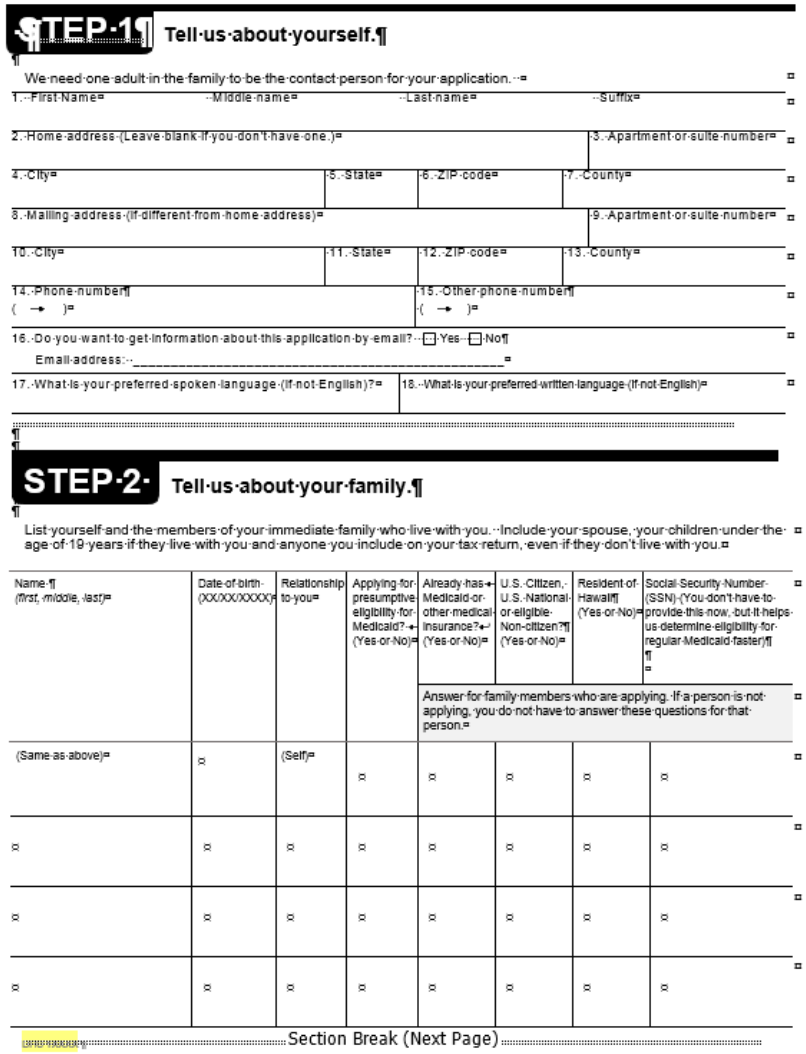
Ask your hospital representative or call us toll free at 1-800-316-8005. If you need help in a language other than English, call toll free at 1-800-316-8005 and tell the customer services representative the language you need. We will get you help at no cost to you. TTY/TTD users call toll free at 1-800-603-1201.

DHS 1XXXX

This is an important letter from the Department of Human Services. Please call the phone number located on the letter. When you call, you will be asked what language you speak and your call will be put on hold for an interpreter. You can also call 1-800-316-8005 for all DHS services.	English
這是一封從人類服務部門發出的重要信件。請撥打信上的電話號碼。當你打電話時，你將會被詢問你講什麼語言，你的通話將被擴展直到接通翻譯服務。其他人類服務部門的服務，你可以致電到 1-800-316-8005.	Cantonese
Ei taropwe mi auchchea seni ewe putain tumwunun aramas (Department of Human Services). Kose mwochen kokkori na nampan foon won na taropwe. Nupwen omw kokko, repwe eisinuk menni kkapas ke sine pwe repwe kkutta ngonuk emon choon chiaku. Ka pwan tongeni kokkori 1-800-316-8005 ren meinisin aninnis seni DHS.	Chuukese
Ceci est une lettre importante du Department of Human Services (DHS). S'il vous plaît, faire un appel téléphonique au numéro de téléphone situé sur la lettre. Lorsque vous téléphonez, quelqu'un va vous demander quelle langue vous parlez, et votre appel sera mis en attente pour un interprète. Vous pouvez aussi téléphoner 1-800-316-8005 pour tous les services de DHS.	French
Dies ist eon wichtiger Brief von der Abteilung Menschlicher Dienste (DHS). Bitte rufen Sie die Telefonnummer, die auf dem Brief gefunden wurde. Wenn Sie rufen, werden Sie gefragt werden, welche Sprache Sie sprechen, und Ihr Anruf wird auf Wartestellung für einen Dolmetscher geschaltet werden. Sie können 1-800-316-8005 für alle DHS Dienste auch rufen.	German
He leka ko'iko'i keia mai ka 'Oihana Lawelawe Kanaka (Department of Human Services). E kelepona mai i ka helu kelepona ma luna o ka leka. Ke kelepona 'oe, e ninau 'ia ana 'oe he aha kau 'olelo 'oiwi a laila e kali 'oe a loa'a ke kanaka mahele 'olelo. Hiki pu ia 'oe ke kelepona i 1-800-316-8005 no na lawelawe a pau a ka 'Oihana Lawelawe Kanaka (DHS).	Hawaiian
Daytoy ket importante nga surat nga naggapu iti Department of Human Services. Pangaasi nga tawagan yo iti numero iti telepono nga nakakabil iti daytoy nga surat. Nu umawag kayo, saludsuden da nu anya iti panagsasao yo ket urayen yo nga maiyallatiw iti tawag yo iti intepreter. Mabalin kayo nga umawag iti 1-800-316-8005 para kadagiti amin nga serbisyo iti DHS.	Ilocano
ハワイ州人道的奉仕局からの大切なお知らせです。この紙面に書かれている番号にお電話ください。電話をされた時に、貴方がどの言語を話されているかを聞かれます、通訳に接続 されるまでしばらくお待ちください。ＤＨＳのどのサービスにも、この電話番号 1-800-316-8005 で対応いたします.	Japanese
인간 서비스 부서에서 보내는 중요한 편지 입니다. 이편지에 기재된 전화번호로 전화를 하시요. 당신이 전화를 할때 당신이 사용하는 언어를 물을것이고 그언어의 통역인에게 연결할것 입니다. 당신은 모든 인간 서비스 부서(디에이치에스)에 도움을 받기 위해서1-800-316-8005 로 전화 할수 있읍니다	Korean
这是一封从人类服务部门发出的重要信件。请拨打信上的电话号码。当你打电话时，你将会被询问你讲什 么语言，你的通话将被擴展直到接通翻译服务。其他人类服务部门的服务，你可以致电到 1-800-316-8005。	Mandarin
Juon in kojela im elap an aurok im ej itok jen ra eo an department of human services. Jouij im call e nomba in im ej bed ilo pepa in ak letta in. Ne koj call, renej kajitok ibbem kin kain kajin eo am im elikin am ba renej ba kwon kottar bwe ren lewoj juon am ri okok. Komaron call 1-800-316-8005 non aolepen ra ko kajojo ilo DHS services.	Marshallese
O se fa'asilasilaga ta'ua lenei mai le Ofisa o le Human Services. Fa'amolemole, vala'au mai i le numera lea o lo'o i luga o lenei tusi. A e vala'au mai, o le a fesili atu po'o le a le gagana e te mo'omia, ona tu'u sa'o lea o lau telefoni i se tagata e mafai ona fesoasoani ia oe. E mafai fo'i ona e vala'au i le number 1-800-316-8005 mo nisi 'au'aunaga mai lenei Ofisa."	Samoan
Ésta es una carta importante de la Sección de Servicios Humanos (DHS). Por favor llame el número de teléfono localizado en la carta. Cuando usted llama, usted se preguntará qué idioma usted habla y su llamada se pondrá en espera para un intérprete. Usted también puede llamar 1-800-316-8005 para todos los servicios de DHS.	Spanish
Ito ay mahalaga na sulat na galling sa Department of Human Services. Mangyaring tawagan ang numero na nakalagay sa sulat na ito. Kung kayo ay tatawag., tatanungin kung ano ang iyong wika at hintayin ninyo hanggat may sumagot na tagasalin. Pwede ninyong tumawag sa 1-800-316-8005 para sa lahat ng serbisio sa	Tagalog
Ko e tohi mahu'inga eni mei he Potungaue Ngaue Ma'ae Kakai. Kataki 'o telefoni ki he fika 'oku ha 'i he tohi ni. 'E fehu'i atu pe ko e ha e fa'ahinga lea 'oku ke lea'aki 'i he taimi te ke ta mai ai pea tnitokoe ke tali kae 'oua kuo ma'u ha toko taha fakatonu lea. Te ke lava 'o ta ki he ki he ngaahi tokoni kotoa 'a e DHS.	Tongan
Đây là lá thơ quang trọng từ các Bộ Phục Vụ Nhân Dân (DHS). Làm ơn gọi xố điện thoại nằm trên lá thơ. Khi bạn gọi, bạn sẽ được hỏi ngôn ngữ nào bạn nói và cú điện thoại của bạn sẽ chờ người thông dịch. Đồng thời bạn cùng có thể gọi số 1-800-316-8005 cho các phục vụ DHS.	Vietnamese Việt Nam
Kini importante nga sulat gikan sa Department of Human Services (DHS). Palihug tawagi ang numero sa maong telepono nga nahimutang sa sulat. Sa imong pagtawag, ikaw pangutan-on kun unsa ang imong pinulongan ug ang imong tawag ilang ipahulat para sa usa ka taghubad sa pinulongan. Mahimo usab nga imong tawagan ang 1-800-316-8005 para sa tanang mga serbisyo sa DHS.	Visayan

DHS 1XXXX

Hospital PE Application



STEP 1 Tell us about yourself.

We need one adult in the family to be the contact person for your application.

1. First Name | Middle name | Last name | Suffix

2. Home address (Leave blank if you don't have one.) | 3. Apartment or suite number

4. City | 5. State | 6. ZIP code | 7. County

8. Mailing address (if different from home address) | 9. Apartment or suite number

10. City | 11. State | 12. ZIP code | 13. County

14. Phone number (→) | 15. Other phone number (→)

16. Do you want to get information about this application by email? ☐ Yes ☐ No

Email address: _____

17. What is your preferred spoken language (if not English)? | 18. What is your preferred written language (if not English)

STEP 2 Tell us about your family.

List yourself and the members of your immediate family who live with you. Include your spouse, your children under the age of 19 years if they live with you and anyone you include on your tax return, even if they don't live with you.

Name (first, middle, last)	Date of birth (XX/XX/XXXX)	Relationship to you	Applying for presumptive eligibility for Medicaid? (Yes or No)	Already has Medicaid or other medical insurance? (Yes or No)	U.S. Citizen, U.S. National or eligible Non-citizen? (Yes or No)	Resident of Hawaii (Yes or No)	Social Security Number (SSN) (You don't have to provide this now, but it helps us determine eligibility for regular Medicaid faster)
				Answer for family members who are applying. If a person is not applying, you do not have to answer these questions for that person.			
(Same as above)		(Self)					

Section Break (Next Page)

STEP 3 Other questions.

Answer these questions for yourself and your family members listed in Step 2. Your answers will make it easier to find out if you and any family member(s) qualify.

Is anyone pregnant who is applying for presumptive eligibility for Medicaid?	☐ Yes ☐ No
If yes, who? _____ How many babies does she expect? _____	
Is anyone who is applying for presumptive eligibility for Medicaid receiving Medicare or Social Security Income (SSI)?	☐ Yes ☐ No
If yes, who? _____	
Is anyone who is applying for presumptive eligibility for Medicaid a parent or caretaker relative? *For example, a grandparent who is the main person taking care of a child.*	☐ Yes ☐ No
If yes, who? _____	
Was anyone who is applying for presumptive eligibility for Medicaid in foster care at age 18?	☐ Yes ☐ No
If yes, who? _____	

STEP 4 Tell us about your family's income.

Write the total income before taxes are taken for all family members listed in Step 2.

- **Job income**: *For example, wages, salaries, and self-employment income.*

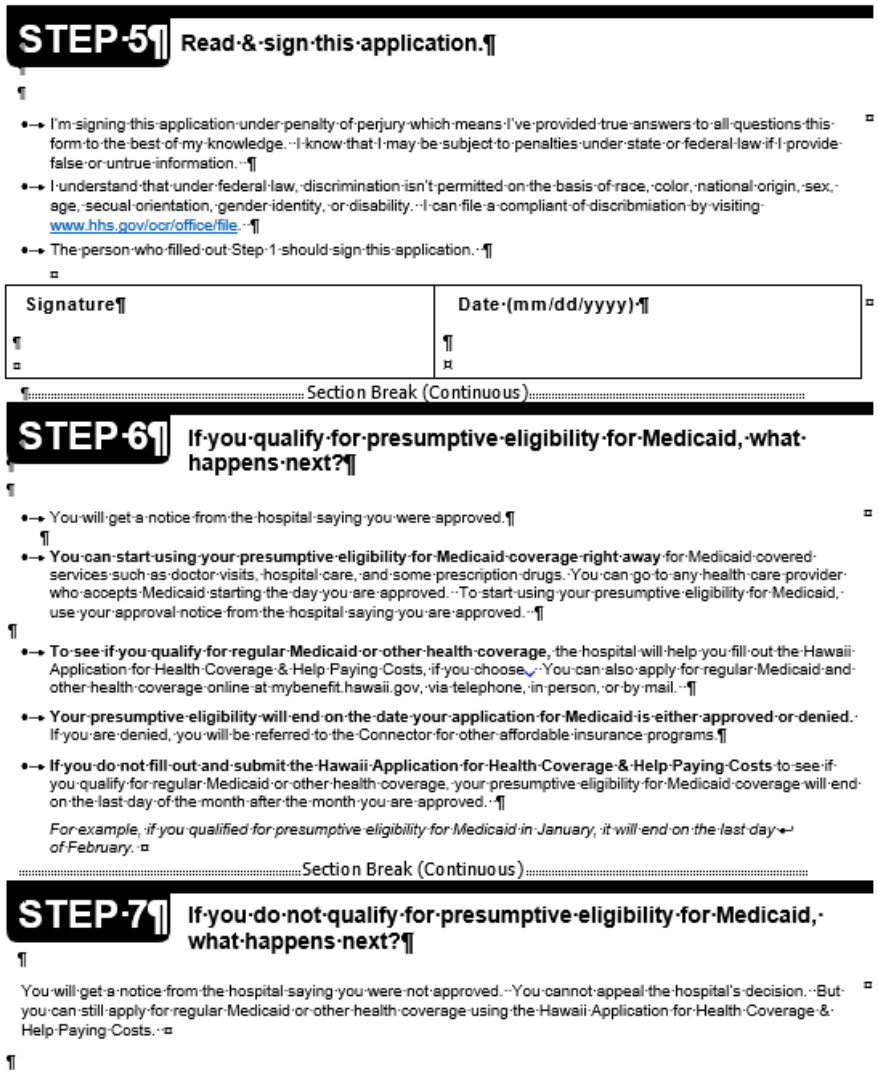
Amount $ How often? *(check one)* ☐ Weekly ☐ Biweekly ☐ Monthly ☐ Yearly

- **Other income** *For example, unemployment checks, alimony, or disability payments from the Social Security Administration ("SSDI"). Do **not** include Supplemental Security Income ("SSI payments") or any child support you receive.*

Amount $ How often? *(check one)* ☐ Weekly ☐ Biweekly ☐ Monthly ☐ Yearly

DHS 1XXXX

Hospital PE Application



STEP 5 Read & sign this application.

- I'm signing this application under penalty of perjury which means I've provided true answers to all questions this form to the best of my knowledge. I know that I may be subject to penalties under state or federal law if I provide false or untrue information.
- I understand that under federal law, discrimination isn't permitted on the basis of race, color, national origin, sex, age, secual orientation, gender identity, or disability. I can file a compliant of discribmiation by visiting www.hhs.gov/ocr/office/file.
- The person who filled out Step 1 should sign this application.

Signature	Date (mm/dd/yyyy)

Section Break (Continuous)

STEP 6 If you qualify for presumptive eligibility for Medicaid, what happens next?

- You will get a notice from the hospital saying you were approved.
- **You can start using your presumptive eligibility for Medicaid coverage right away** for Medicaid covered services such as doctor visits, hospital care, and some prescription drugs. You can go to any health care provider who accepts Medicaid starting the day you are approved. To start using your presumptive eligibility for Medicaid, use your approval notice from the hospital saying you are approved.
- **To see if you qualify for regular Medicaid or other health coverage,** the hospital will help you fill out the Hawaii Application for Health Coverage & Help Paying Costs, if you choose. You can also apply for regular Medicaid and other health coverage online at mybenefit.hawaii.gov, via telephone, in person, or by mail.
- **Your presumptive eligibility will end on the date your application for Medicaid is either approved or denied.** If you are denied, you will be referred to the Connector for other affordable insurance programs.
- **If you do not fill out and submit the Hawaii Application for Health Coverage & Help Paying Costs** to see if you qualify for regular Medicaid or other health coverage, your presumptive eligibility for Medicaid coverage will end on the last day of the month after the month you are approved.

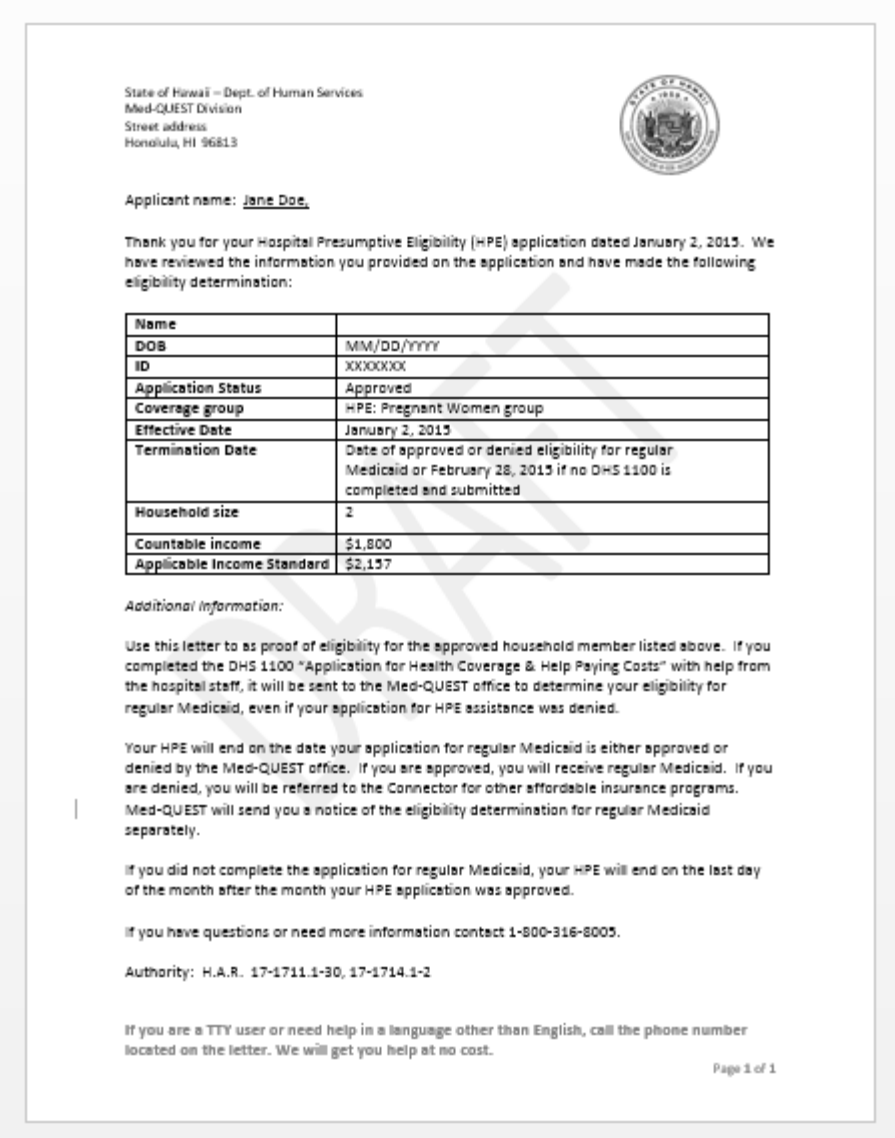
  For example, if you qualified for presumptive eligibility for Medicaid in January, it will end on the last day of February.

Section Break (Continuous)

STEP 7 If you do not qualify for presumptive eligibility for Medicaid, what happens next?

You will get a notice from the hospital saying you were not approved. You cannot appeal the hospital's decision. But you can still apply for regular Medicaid or other health coverage using the Hawaii Application for Health Coverage & Help Paying Costs.

Sample Approval Letter



State of Hawaii – Dept. of Human Services
Med-QUEST Division
Street address
Honolulu, HI 96813

Applicant name: Jane Doe,

Thank you for your Hospital Presumptive Eligibility (HPE) application dated January 2, 2015. We have reviewed the information you provided on the application and have made the following eligibility determination:

Name	
DOB	MM/DD/YYYY
ID	XXXXXX
Application Status	Approved
Coverage group	HPE: Pregnant Women group
Effective Date	January 2, 2015
Termination Date	Date of approved or denied eligibility for regular Medicaid or February 28, 2015 if no DHS 1100 is completed and submitted
Household size	2
Countable income	$1,800
Applicable Income Standard	$2,137

Additional information:

Use this letter to as proof of eligibility for the approved household member listed above. If you completed the DHS 1100 "Application for Health Coverage & Help Paying Costs" with help from the hospital staff, it will be sent to the Med-QUEST office to determine your eligibility for regular Medicaid, even if your application for HPE assistance was denied.

Your HPE will end on the date your application for regular Medicaid is either approved or denied by the Med-QUEST office. If you are approved, you will receive regular Medicaid. If you are denied, you will be referred to the Connector for other affordable insurance programs. Med-QUEST will send you a notice of the eligibility determination for regular Medicaid separately.

If you did not complete the application for regular Medicaid, your HPE will end on the last day of the month after the month your HPE application was approved.

If you have questions or need more information contact 1-800-316-8005.

Authority: H.A.R. 17-1711.1-30, 17-1714.1-2

If you are a TTY user or need help in a language other than English, call the phone number located on the letter. We will get you help at no cost.

Page 1 of 1

Sample Denial Letter

State of Hawai – Dept. of Human Services
Med-QUEST Division
Street address
Honolulu, HI 96813

Applicant name: Jane Doe,

Thank you for your Hospital Presumptive Eligibility (HPE) application dated January 2, 2015. We have reviewed the information you provided on the application and have made the following eligibility determination:

Name	
DOB	MM/DD/YYYY
ID	XXXXXXX
Application Status	Denied
Coverage group	HPE: Pregnant Women group
Effective Date	January 2, 2015
Denial Reason	Excess income
Household size	2
Countable income	$5,800
Applicable Income Standard	$2,157

Additional information:

If you completed the DHS 1100 "Application for Health Coverage & Help Paying Costs" with help from the hospital staff, it will be sent to the Med-QUEST office to determine your eligibility for regular Medicaid, even if your application for HPE assistance was denied.

If you are approved, you will receive regular Medicaid. If you are denied, you will be referred to the Connector for other affordable insurance programs. Med-QUEST will send you a notice of the eligibility determination for regular Medicaid separately.

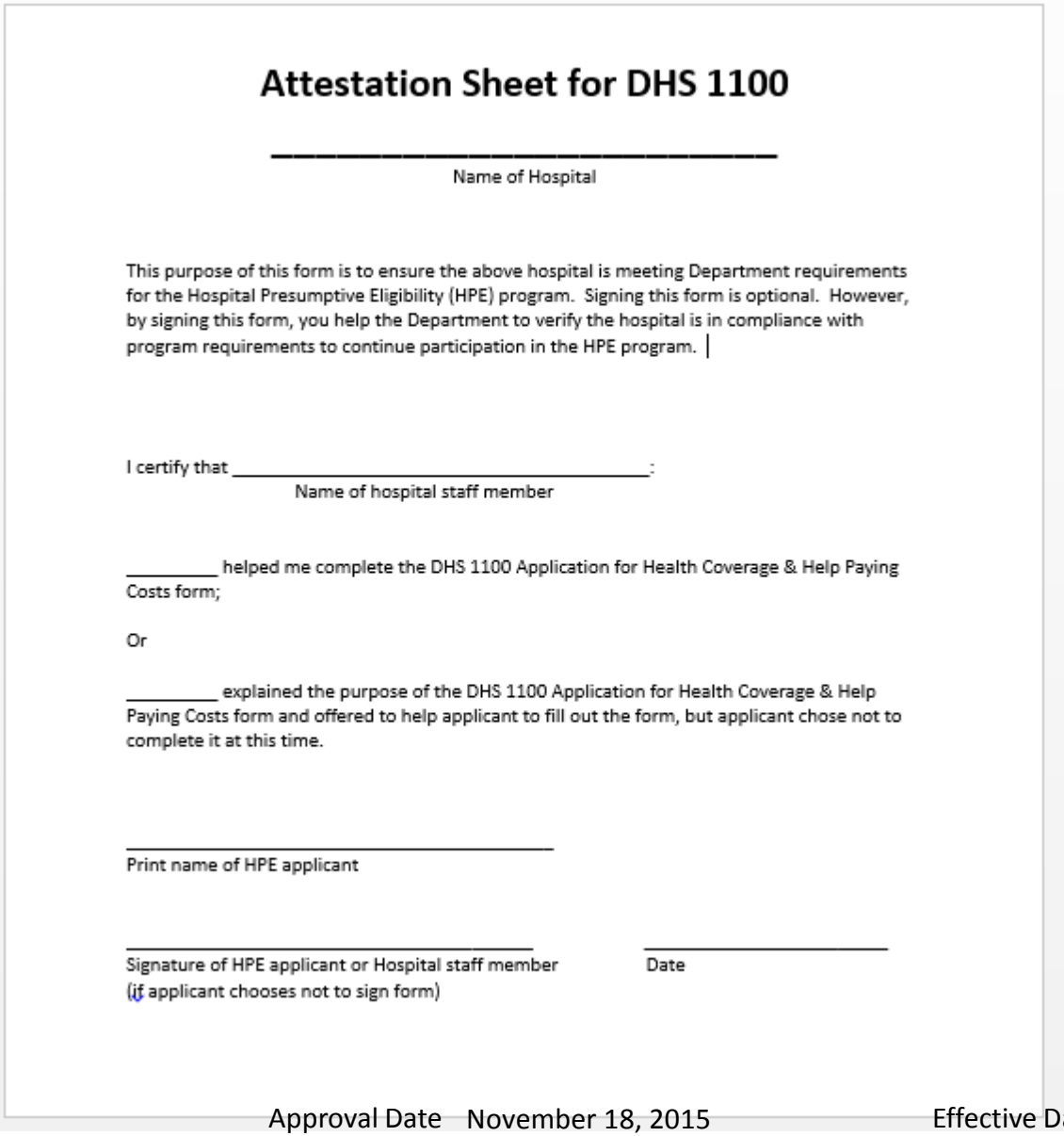
If you have questions or need more information contact 1-800-316-8005.

Authority: H.A.R. 17-1711.1-30, 17-1714.1-2

If you are a TTY user or need help in a language other than English, call the phone number located on the letter. We will get you help at no cost.

Page 1 of 1

Attestation Sheet for DHS 1100



Attestation Sheet for DHS 1100

_____

Name of Hospital

This purpose of this form is to ensure the above hospital is meeting Department requirements for the Hospital Presumptive Eligibility (HPE) program. Signing this form is optional. However, by signing this form, you help the Department to verify the hospital is in compliance with program requirements to continue participation in the HPE program.

I certify that _____:

Name of hospital staff member

_____ helped me complete the DHS 1100 Application for Health Coverage & Help Paying Costs form;

Or

_____ explained the purpose of the DHS 1100 Application for Health Coverage & Help Paying Costs form and offered to help applicant to fill out the form, but applicant chose not to complete it at this time.

_____

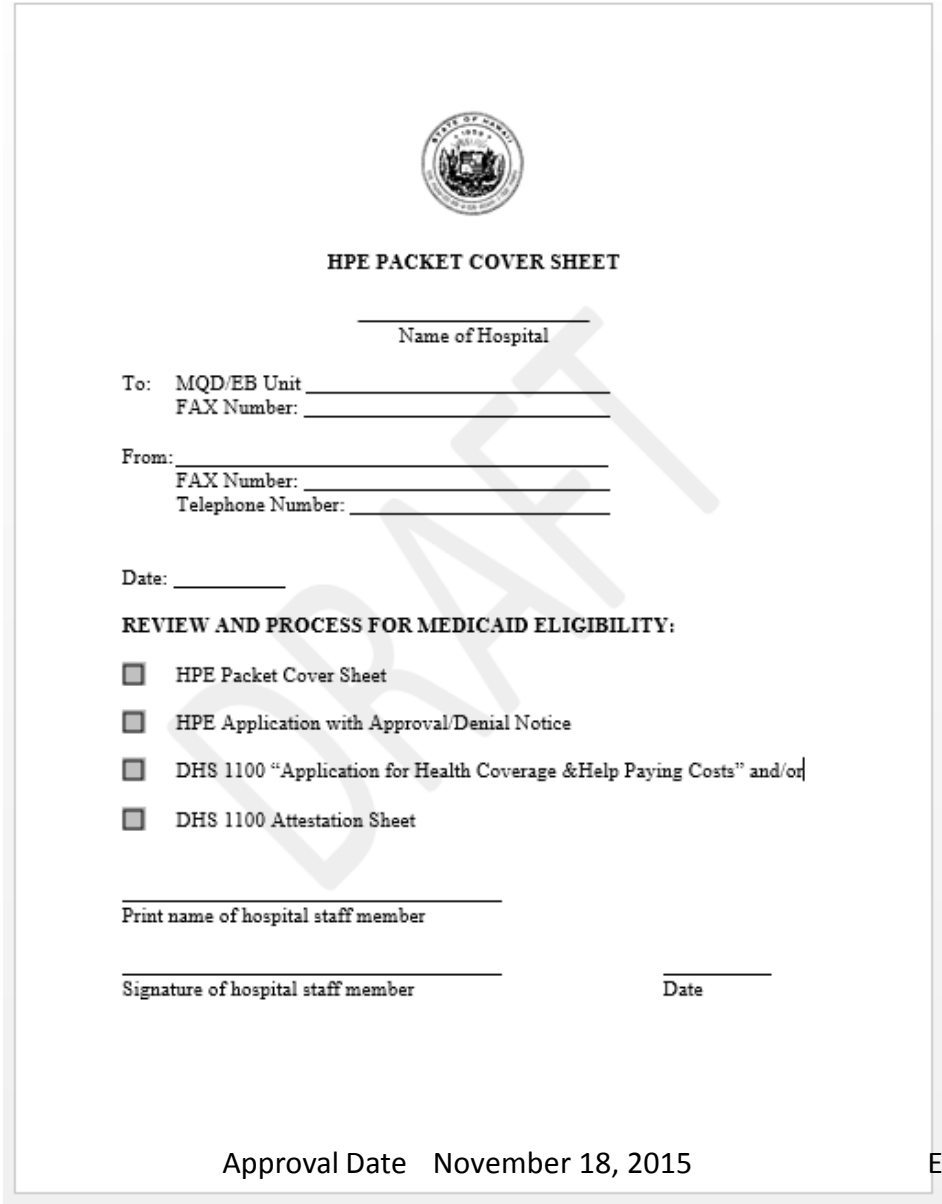
Print name of HPE applicant

_____ _____

Signature of HPE applicant or Hospital staff member (if applicant chooses not to sign form)

Date

Sample of Cover Letter



HPE PACKET COVER SHEET

_____
Name of Hospital

To: MQD/EB Unit _____
FAX Number: _____

From: _____
FAX Number: _____
Telephone Number: _____

Date: _____

REVIEW AND PROCESS FOR MEDICAID ELIGIBILITY:

- ☐ HPE Packet Cover Sheet
- ☐ HPE Application with Approval/Denial Notice
- ☐ DHS 1100 "Application for Health Coverage &Help Paying Costs" and/or
- ☐ DHS 1100 Attestation Sheet

_____
Print name of hospital staff member

_____ _____
Signature of hospital staff member Date

DHS 1100 Application for Health Coverage & Help Paying Costs

State of Hawaii
Department of Human Services
Hawaii Health Connector

Application for Health Coverage & Help Paying Costs

THINGS TO KNOW

Use this application to see what coverage choices you qualify for

- Affordable private health insurance plans that offer comprehensive coverage to help you stay well
- A new tax credit that can immediately help pay your premiums for health coverage
- Free or low-cost insurance from Medicaid or the Children's Health Insurance Program (CHIP)

Who can use this application?

- Use this application to apply for you or anyone in your family.
- Apply even if you or your child already has health coverage. You could be eligible for lower-cost or free coverage.
- Families that include immigrants can apply. You can apply for your child even if you aren't eligible for coverage. Applying won't affect your immigration status or chances of becoming a permanent resident or citizen.
- If someone is helping you fill out this application, you may need to complete Appendix C.

Apply faster online

- Apply faster online at **mybenefits.hawaii.gov**.
- If you want to purchase insurance without help, apply directly at **hawaiihealthconnector.com**

What you may need to apply

- Social Security Numbers (or document numbers for any legal immigrants who need insurance)
- Employer and income information for everyone in your family (for example, from paystubs, W-2 forms, or wage and tax statements)
- Policy numbers for any current health insurance
- Information about any job-related health insurance available to your family

Why do we ask for this information?

We ask about income and other information to let you know what coverage you qualify for and if you can get any help paying for it. **We'll keep all the information you provide private and secure, as required by law.** To view the Privacy Act Statement, go to mybenefits.hawaii.gov.

What happens next?

Send your complete, signed application to the address on page 7. **If you don't have all the information we ask for, sign and submit your application anyway.** We'll follow-up with you within 1–2 weeks. You'll get instructions on the next steps to complete your health coverage. If you don't hear from us, visit **mybenefits.hawaii.gov** or call **1-877-628-5076**. Filling out this application doesn't mean you have to buy health coverage.

Get help with this application

- **Online: mybenefits.hawaii.gov**
- **Phone:** Call the Contact Center at **1-877-628-5076** for assistance with completing and submitting an application or getting information on the status of your application.
- **In person:** There may be counselors in your area who can help. Visit our website or call **1-877-628-5076** for more information.
- **Medicaid:** For specific questions on Medicaid/CHIP eligibility, call **1-888-764-7586**.

NEED HELP WITH YOUR APPLICATION? Visit mybenefits.hawaii.gov or call us at 1-877-628-5076. Language assistance is available. If you need help in a language other than English, call 1-877-628-5076 and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY/TDD users should call 1-855-858-8604.

DHS 1100 (REV. 10/14)

This is an important letter from the Department of Human Services. Please call the phone number located on the letter. When you call, you will be asked what language you speak and your call will be put on hold for an interpreter. You can also call 1-888 - 764-7586 for all DHS services.	English
這是一封從人類服務部門發出的重要信件。請撥打信上的電話號碼。當你打電話時，你將會被詢問你講什麼語言，你的通話將被擱置直到接通翻譯服務。其他人類服務部門的服務，您可以致電到 1- 888 - 764-7586.	Cantonese
Ei taropwe mi auchchea seni ewe putain tumwunun aramas (Department of Human Services). Kose mwochen kokkori na nampan foon won na taropwe. Nupwen omw kokko, repwe eisinuk menni kkapas ke sine pwe repwe kkutta ngonuk emon choon chiaku. Ka pwan tongeni kokkori 1-888-764-7586 ren meinisin aninnis seni DHS.	Chuukese
Ceci est une lettre importante du Department of Human Services (DHS). S'il vous plaît, faire un appel téléphonique au numéro de téléphone situé sur la lettre. Lorsque vous téléphonez, quelqu'un va vous demander quelle langue vous parlez, et votre appel sera mis en attente pour un interprète. Vous pouvez aussi téléphoner 1-888 - 764-7586 pour tous les services de DHS.	French
Dies ist eon wichtiger Brief von der Abteilung Menschlicher Dienste (DHS). Bitte rufen Sie die Telefonnummer, die auf dem Brief gefunden wurde. Wenn Sie rufen, werden Sie gefragt werden, welche Sprache Sie sprechen, und Ihr Anruf wird auf Wartestellung für einen Dolmetscher geschaltet werden. Sie können 1-888-764-7586 für alle DHS Dienste auch rufen.	German
He leka ko'iko'i keia mai ka 'Oihana Lawelawe Kanaka (Department of Human Services). E kelepona mai i ka helu kelepona ma luna o ka leka. Ke kelepona 'oe, e ninau 'ia ana 'oe he aha kau 'olelo 'oiwi a laila e kali 'oe a loa'a ke kanaka mahele 'olelo. Hiki pu ia 'oe ke kelepona i 1-888-764-7586 no na lawelawe a pau a ka 'Oihana Lawelawe Kanaka (DHS).	Hawaiian
Daytoy ket importante nga surat nga naggapu iti Department of Human Services. Pangaasi nga tawagan yo iti numero iti telepono nga nakakabil iti daytoy nga surat. Nu umawag kayo, saludsuden da nu anya iti panagsasao yo ket urayen yo nga maiyallatiw iti tawag yo iti intepreter. Mabalin kayo nga umawayo iti 1-888-764-7586 para kadagiti amin nga serbisyo iti DHS.	Ilocano
ハワイ州人道的幸仕局からの大切なお知らせです。この紙面に書かれている番号にお電話ください。電話をされた時に、貴方がどの言語を話されているかを聞かれます、通訳に接続されるまでしばらくお待ちください。DHSのどのサービスにも、この電話番号１－８８８－７６４－７５８６で対応いたします。	Japanese
인간 서비스 부서에서 보내는 중요한 편지 입니다. 이편지에 기재된 전화번호로 전화를 하시요. 당신이 전화를 할때 당신이 사용하는 언어를 물을것이고 그언어의 통역인에게 연결할것 입니다. 당신은 모든 인간 서비스 부서(디에이치에스)에 도움을 받기 위해서 1-888-764-7586 로 전화 할수 있읍니다	Korean
这是一封从人类服务部门发出的重要信件。请拔打信上的电话号码。当你打电话时，你将会被询问你讲什么语言，您的通话将被搁置直到接通翻译服务。其他人类服务部门的服务，您可以致电到 1-888 - 764-7586。	Mandarin
Juon in kojela im elap an aurok im ej itok jen ra eo an department of human services. Jouij im call e nomba in im ej bed ilo pepa in ak letta in. Ne koj call, renej kajitok ibbem kin kain kajin eo am im elikin am ba renej ba kwon kottar bwe ren lewoj juon am ri okok. Komaron call 1-888-764-7586 non aolepen ra ko kajoio ilo DHS services.	Marshallese
O se fa'asilasilaga ta'ua lenei mai le Ofisa o le Human Services. Fa'amolemole, vala'au mai i le numera lea o lo'o i luga o lenei tusi. A e vala'au mai, o le a fesili atu po'o le a le gagana e te mo'omia, ona tu'u sa'o lea o lau telefoni i se tagata e mafai ona fesoasoani ia oe. E mafai fo'i ona e vala'au i le number 1-888-764-7586 mo nisi 'au'aunaga mai lenei Ofisa."	Samoan
Ésta es una carta importante de la Sección de Servicios Humanos (DHS). Por favor llame el número de teléfono localizado en la carta. Cuando usted llama, usted se preguntará qué idioma usted habla y su llamada se pondrá en espera para un intérprete. Usted también puede llamar 1-888 - 764-7586 para todos los servicios de DHS.	Spanish
Ito ay mahalaga na sulat na galling sa Department of Human Services. Mangyaring tawagan ang numero na nakalagay sa sulat na ito. Kung kayo ay tatawag, tatanungin kung ano ang iyong wika at hintayin ninyo hanggat may sumagot na tagasalin. Pwede ninyong tumawag sa 1-888-764-7586 para sa lahat ng serbisyo sa DHS.	Tagalog
Ko e tohi mahu'inga eni mei he Potungaue Ngaue Ma'ae Kakai. Kataki 'o telefoni ki he fika 'oku ha 'i he tohi ni. 'E fehu'i atu pe ko e ha e fa'ahinga lea 'oku ke lea'aki 'i he taimi te ke ta mai ai pea tnitokoe ke tali kae 'oua kuo ma'u ha toko taha fakatonu lea. Te ke lava 'o ta ki he ki he ngaahi tokoni kotoa 'a e DHS.	Tongan
Đây là lá thơ quang trong từ các Bộ Phục Vụ Nhân Dân (DHS). Làm ơn gọi số điện thoại nằm trên lá thơ. Khi bạn gọi, bạn sẽ được hỏi ngôn ngữ nào bạn nói và cú điện thoại của bạn sẽ chờ người thông dịch. Đồng thời bạn cũng có thể gọi số 1-888-764-7586 cho các phục vụ DHS.	Vietnamese Việt Nam
Kini importante nga sulat gikan sa Department of Human Services (DHS). Palihug tawagi ang numero sa maong telepono nga nahimutang sa sulat. Sa imong pagtawag, ikaw pangutan-on kun unsa ang imong pinulongan ug ang imong tawag ilang ipahulat para sa usa ka taghubad sa pinulongan. Mahimo usab nga imong tawagan ang 1-888-764-7586 para sa tanang mga serbisyo sa DHS.	Visayan

NEED HELP WITH YOUR APPLICATION? Visit mybenefits.hawaii.gov or call us at 1-877-628-5076. Language assistance is available. If you need help in a language other than English, call 1-877-628-5076 and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY/TDD users should call 1-855-858-8604.

DHS 1100 (REV. 10/14)

DHS 1100 Application for Health Coverage & Help Paying Costs

STEP 1 Tell us about yourself.

(We need one adult in the family to be the contact person for your application.)

1. First name	Middle name	Last name	Suffix

2. Home address (Leave blank if you don't have one.) | 3. Apartment or suite number

4. City | 5. State | 6. Zip code | 7. County

8. Mailing address (if different from home address) | 9. Apartment or suite number

10. City | 11. State | 12. Zip code | 13. County

14. Phone number ( ) – | 15. Other phone number ( ) –

16. Do you want to get information about this application by email? ☐ Yes ☐ No

Email address: _____

17. What is your preferred spoken language (if not English)?

18. What is your preferred written language (if not English)?

19. How many family members live with you?

20. Is any family member you usually live with incarcerated (detained or jailed) or residing in the Hawaii State Hospital?
☐ Yes ☐ No
If yes, please list their name(s):

STEP 2 Tell us about your family.

Who do you need to include on this application?

Tell us about all the family members who live with you. If you file taxes, we need to know about everyone on your tax return. (You don't' need to file taxes to get health coverage).

DO Include:
- Yourself
- Your spouse
- Your children under 19 who live with you
- Your unmarried partner who needs health coverage
- Anyone you include on our tax return, even if they don't live with you
- Anyone else under 19 who you take care of and lives with you

You DON'T have to include:
- Your unmarried partner who doesn't need health coverage
- Your unmarried partner's children
- Your parents who live with you, but file their own tax return (if you're over 19)
- Other adult relatives who file their own tax return

The amount of assistance or type of program you qualify for depends on the number of people in your family and their incomes. This information helps us make sure everyone get the best coverage they can.

Complete Step 2 for each person in your family. Start with yourself, then add other adults and children. If you have more than two (2) people in your family, you'll need to make a copy of the pages and attach them. You don't need to provide immigration status or a Social Security Number (SSN) for family members who don't need health coverage. We'll keep all the information you provide private and secure as required by law. We'll use personal information only to check if you're eligible for health coverage.

STEP 2: PERSON 1 (Start with yourself)

Complete Step 2 for yourself, your spouse/partner and children who live with you and/or anyone on your same federal income tax return if you file one. See page 1 for more information about who to include. If you don't file a tax return, remember to still add family members who live with you.

1. First name	Middle name	Last name	Suffix	2. Relationship to you? SELF

3. Date of birth (mm/dd/yyyy) __/__/____ 4. Gender ☐ Male ☐ Female

5. Social Security Number (SSN) ___-___-____

We need this if you want health coverage and have an SSN. Providing your SSN can be helpful if you don't want health coverage too since it can speed up the application process. We use SSNs to check income and other information to see who's eligible for help with health coverage costs. If someone wants help getting an SSN, call 1-800-772-1213 or visit **socialsecurity.gov**. TTY users should call 1-800-325-0778.

6. Do you plan to file a federal income tax return NEXT YEAR?
(You can still apply for health insurance even if you don't file a federal income tax return.)
☐ **Yes. If yes**, please answer questions a–c. ☐ **No. If no**, skip to question c.

a. Will you file jointly with a spouse? ☐ Yes ☐ No
If yes, name of spouse: _____

b. Will you claim any dependents on your tax return? ☐ Yes ☐ No
If yes, list name(s) of dependents: _____

c. Will you be claimed as a dependent on someone's tax return? ☐ Yes ☐ No
If yes, please list the name of the tax filer: _____
How are you related to the tax filer? _____

7. Are you pregnant? ☐ Yes ☐ No **If yes**, how many babies are expected during this pregnancy? _____ Expected Due Date _____

8. Do you need health coverage?
(Even if you have insurance, there might be a program with better coverage or lower costs.)
☐ **Yes. If yes**, answer all the questions below. ☐ **No. If no**, SKIP to **the income questions** on page 3. Leave **the rest** of this page blank.

9. Do you have a disability that will last more than twelve (12) months? ☐ Yes ☐ No
a. Do you currently receive long term care nursing services: ☐ **Yes**, in a nursing facility ☐ **Yes**, in my home in the community ☐ **No**
b. Have you received long term care nursing services in the last three (3) months? ☐ **Yes. If yes**, what date(s)? _____ ☐ **No**
c. Do you think you need long term care nursing services now? ☐ Yes ☐ No
d. Do you receive Supplemental Security Income (SSN)? ☐ Yes ☐ No

10. Did you receive any medical services in the past ten (10) calendar days immediately prior to the date of this application?
☐ **Yes.** If yes, what date(s)? _____ ☐ **No**

11. Are you a U.S. citizen or U.S. national? ☐ **Yes. If yes**, skip to Question 13. ☐ **No**

12. If you aren't a U.S. citizen or U.S. national, please provide the information below.
a. Immigration **document** type _____
b. Document ID number _____
c. When did you enter the U.S.? _____
d. Are you a citizen of the Federated State of Micronesia, the Republic of the Marshall Islands, and Palau. ☐ Yes ☐ No
e. Are you, or your spouse or parent, a veteran or an active-duty member of the U.S. military? ☐ Yes ☐ No

13. Are you the primary or one of the primary person(s) taking care of a child under age 19 years that lives with you? ☐ Yes ☐ No

14. Were you in foster care at age 18 or older in Hawaii? ☐ Yes ☐ No

15. Are you a full-time student? ☐ Yes ☐ No

16. If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply.)
☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other _____

17. Race (OPTIONAL – check all that apply.)

☐ White	☐ Black or African American	☐ Filipino	☐ Vietnamese	☐ Guamanian or Chamorro
☐ Asian Indian	☐ American Indian or Alaska Native	☐ Japanese	☐ Other Asian	☐ Other Pacific Islander
☐ Chinese	☐ Native Hawaiian	☐ Korean	☐ Samoan	☐ Other _____

DHS 1100 Application for Health Coverage & Help Paying Costs

STEP 2: PERSON 1 (Continue with yourself)

CURRENT Job & Income Information

☐ **Employed** If you're currently employed, tell us about your income. Start with question 18.

☐ **Self-employed** Skip to question 27.

☐ **Not employed** Skip to question 28.

CURRENT JOB 1:

18. Employer name and address

19. Employer phone number ( ) –

20. Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly

$_____

21. Average hours worked each WEEK

CURRENT JOB 2: (If you have more jobs and need more space, attach another sheet of paper.)

22. Employer name and address

23. Employer phone number ( ) –

24. Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly

$_____

25. Average hours worked each WEEK

26. In the past year, did you: ☐ Change jobs ☐ Stop working ☐ Start working fewer hours ☐ None of these

27. If self-employed, answer the following questions:

a. Type of work _____

b. How much net income (profit business expenses are paid) will you get from this self-employment this month?

$_____

28. **OTHER INCOME THIS MONTH:** Check all that apply, and give the amount and how often you get it.

NOTE: You don't need to tell us about child support or veteran's payment.

☐ Unemployment	$_____	How often? _____	☐ Net farming/fishing	$_____	How often? _____
☐ Pensions	$_____	How often? _____	☐ Net rental/royalty	$_____	How often? _____
☐ Social Security	$_____	How often? _____	☐ Other income	$_____	How often? _____
☐ Retirement accounts	$_____	How often? _____	Type: _____		
☐ Alimony received	$_____	How often? _____			

29. **DEDUCTIONS:** Check all that apply, and give the amount and how often you get it.

If you pay for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower.

NOTE: You shouldn't include a cost that you already considered in your answer to net self-employment (question 27b).

☐ Alimony paid	$_____	How often? _____	☐ Other deductions	$_____	How often? _____
☐ Student loan interest	$_____	How often? _____	Type: _____		

30. **NET YEARLY INCOME:** Complete if your net income changes a lot from month to month. **If you don't expect changes to your monthly income, skip to the next person.**

Your total income this year	Your total income next year (if you think it will be different)
$	$

THANKS! This is all we need to know about you.

If there is 2 or more people to include, please make a copy of STEP 2: PERSON 2 (Pages 4 and 5) and Complete

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STEP 2: PERSON 2

Complete Step 2 for yourself, your spouse/partner and children who live with you and/or anyone on your same federal income tax return if you file one. See page 1 for more information about who to include. If you don't file a tax return, remember to still add family members who live with you.

1. First name	Middle name	Last name	Suffix	2. Relationship to PERSON 1?

3. Date of birth (mm/dd/yyyy) ☐☐/☐☐/☐☐☐☐ 4. Gender ☐ Male ☐ Female

5. Social Security Number (SSN) ☐☐☐-☐☐-☐☐☐☐

We need this if you want health coverage and have an SSN.

6. Does PERSON 2 live at the same address as you? ☐ Yes ☐ No

If no, list address: _____

7. Does PERSON 2 plan to file a federal income tax return NEXT YEAR?
(You can still apply for health insurance even if you don't file a federal income tax return.)

☐ **Yes. If yes**, please answer questions a–c. ☐ **No. If no**, skip to question c.

a. Will PERSON 2 file jointly with a spouse? ☐ Yes ☐ No

If yes, name of spouse: _____

b. Will PERSON 2 claim any dependents on his/her tax return? ☐ Yes ☐ No

If yes, list name(s) of dependents: _____

c. Will PERSON 2 be claimed as a dependent on someone's tax return? ☐ Yes ☐ No

If yes, please list the name of the tax filer: _____

How is PERSON 2 related to the tax filer? _____

8. Is PERSON 2 pregnant? ☐ Yes ☐ No **If yes**, how many babies are expected during this pregnancy? ____ Expected Due Date _____

9. Does PERSON 2 need health coverage?
(Even if they have insurance, there might be a program with better coverage or lower costs.)

☐ **Yes. If yes**, answer all the questions below. ☐ **No. If no**, SKIP to **the income questions** on page 5. Leave **the rest** of this page blank.

10. Does PERSON 2 have a disability that will last more than twelve (12) months? ☐ Yes ☐ No
a. Does PERSON 2 currently receive long term care nursing services: ☐ Yes, in a nursing facility ☐ Yes, in my home in the community ☐ No
b. Has PERSON 2 received long term care nursing services in the last three (3) months? ☐ Yes. **If yes**, what date(s)? _____ ☐ No
c. Does PERSON 2 need long term care nursing services now? ☐ Yes ☐ No
d. Does PERSON 2 receive Supplemental Security Income (SSI)? ☐ Yes ☐ No

11. Did PERSON 2 receive any medical services in the past ten (10) calendar days immediately prior to the date of this application?
☐ Yes. If yes, what date(s)? _____ ☐ No

12. Is PERSON 2 a U.S. citizen or U.S. national? ☐ Yes. **If yes**, skip to Question 14. ☐ No

13. If PERSON 2 isn't a U.S. citizen or U.S. national, please provide the information below.
a. Immigration document type _____
b. Document ID number _____
c. When did PERSON 2 enter the U.S.? _____
d. Is PERSON 2 a citizen of the Federated State of Micronesia, the Republic of the Marshall Islands or Palau? ☐ Yes ☐ No
e. Is PERSON 2, or their spouse or parent, a veteran or an active-duty member of the U.S. military? ☐ Yes ☐ No

14. Is PERSON 2 the primary or one of the primary person(s) taking care of a child under age 19 years that lives with you? ☐ Yes ☐ No

15. Was PERSON 2 in foster care at age 18 or older in Hawaii? ☐ Yes ☐ No

16. Is PERSON 2 a full-time student? ☐ Yes ☐ No

17. If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply.)
☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other_____

18. Race (OPTIONAL – check all that apply.)

☐ White	☐ Black or African American	☐ Filipino	☐ Vietnamese	☐ Guamanian or Chamorro
☐ Asian Indian	☐ American Indian or Alaska Native	☐ Japanese	☐ Other Asian	☐ Other Pacific Islander
☐ Chinese	☐ Native Hawaiian	☐ Korean	☐ Samoan	☐ Other _____

Now, tell us about any income from PERSON 2 on the back.

Effective Date: January 1, 2014

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DHS 1100 Application for Health Coverage & Help Paying Costs

STEP 2: PERSON 2

CURRENT Job & Income Information

☐ **Employed** If you're currently employed, tell us about your income. Start with question 19.

☐ **Self-employed** Skip to question 28.

☐ **Not employed** Skip to question 29.

CURRENT JOB 1:

19. Employer name and address

20. Employer phone number ( ) –

21. Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly

$_____

22. Average hours worked each WEEK

CURRENT JOB 2: (If you have more jobs and need more space, attach another sheet of paper.)

23. Employer name and address

24. Employer phone number ( ) –

25. Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly

$_____

26. Average hours worked each WEEK

27. In the past year, did PERSON 2: ☐ Change jobs ☐ Stop working ☐ Start working fewer hours ☐ None of these

28. **If self-employed, answer the following questions:**

a. Type of work _____

b. How much net income (profit once business expenses are paid) will you get form this self-employment this month?
$_____

29. **OTHER INCOME THIS MONTH:** Check all that apply, and give the amount and how often you get it.
NOTE: You don't need to tell us about child support or veteran's payment.

☐ Unemployment $_____ How often? _____
☐ Pensions $_____ How often? _____
☐ Social Security $_____ How often? _____
☐ Retirement accounts $_____ How often? _____
☐ Alimony received $_____ How often? _____
☐ Net farming/fishing $_____ How often? _____
☐ Net rental/royalty $_____ How often? _____
☐ Other income $_____ How often? _____
Type: _____

30. **DEDUCTIONS:** Check all that apply, and give the amount and how often you get it.
If PERSON 2 pays for certain things that can be deducted on a federal income tax return, telling us about them could make the cost health coverage a little lower.
NOTE: You shouldn't include a cost that you already considered in your answer to net self-employment (question 28b).

☐ Alimony paid $_____ How often? _____
☐ Student loan interest $_____ How often? _____
☐ Other deductions $_____ How often? _____
Type: _____

31. **NET YEARLY INCOME:** Complete if PERSON 2 net income changes a lot from month to month.
If you don't except changes to PERSON 2 monthly income, skip to the next section.

PERSON 2's total income this year
$

PERSON 2's total income next year (if you think it will be different)
$

THANKS! This is all we need to know about PERSON 2.

If there are no more people to include, skip to next page.

STEP 3 American Indian or Alaska Native (AI/AN) family member(s)

1. **Are you or is anyone in your family American Indian or Alaska Native.**

☐ **Yes. If yes,** go to Appendix B.
☐ **No. If No,** skip Step 4.

STEP 4 Your Family's Health Coverage

Answer these questions for anyone who need health coverage.

1. Does anyone have health coverage or health insurance other than Medicaid?

☐ **Yes. If yes,** check the type of coverage and write the person(s) name(s) on the line provided and additional information as appropriate.

☐ Employer insurance_____
Name of health insurance:_____
Policy number:_____
Is this COBRA coverage? ☐ Yes ☐ No
Is this a retiree health plan? ☐ Yes ☐ No

☐ Medicare_____
☐ TRICARE_____
(Don't check if you have direct care or Line of Duty)
☐ VA health care programs_____
☐ Peace Corp_____
☐ Other_____
Name of health insurance:_____
Policy number:_____
Is this a limited-benefit plan (like a school accident policy)? ☐ Yes ☐ No

☐ **No**

2. Is anyone listed on this application offered health coverage from a job?
(Check YES even if the coverage is from someone else's job, such as a parent or spouse.)

☐ **Yes. If yes,** you'll need to complete and include Appendix A. Is this a state employee benefit plan? ☐ Yes ☐ No

☐ **No. If no,** continue to Step 5.

PRA Disclosure Statement
According to the Paper work Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1191. The time required to complete this information collection is estimated to average [Insert Time (hours or minutes)] per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestion for improving this from, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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!!!SIGNATURE REQUIRED BELOW!!!

STEP 5 Read and sign this application

- I'm signing this application under penalty of perjury which means I've provided true answers to all the questions on this form to the best of my knowledge. I know that I may be subject to penalties under state or federal law if I provide false and/or untrue information.
- I understand I must tell the Department of Human Services or the Hawaii Health Connector if anything changes (and is different than) what I wrote on this application. I can visit **mybenefits.hawaii.gov** or call **1877-628-5076** to report any changes. I understand that a change in my information could affect the eligibility for member(s) of my household.
- I understand that under federal law, discrimination isn't permitted on the basis of race, color, national origin, sex, age, sexual orientation gender identity, or disability. I can file a complaint of discrimination by visiting **www.hhs.gov/ocr/office/file**.
- I understand the Department of Human services and the Hawaii Health Connector will obtain information to verify eligibility with electronic databases, to include but not limited to, the Internal Revenue Services (IRS), Social Security Administration (SSA), Department of Homeland Security (DHS) or a consumer reporting agency. If the information doesn't match, we may ask to you send us proof.

Renewal of coverage in future years

To make it easier to determine my eligibility for help paying for health coverage in future years, I agree to allow the Hawaii Health Connector to use income data, including information from tax returns. The Hawaii Health Connector will send me a notice, let me make any changes, and I can opt out at any time.

Yes, renew my eligibility automatically for the next
☐ 5 years (the maximum number of years allowed), or for a shorter number of years:
☐ 4 years ☐ 3 years ☐ 2 years ☐ 1 years ☐ Don't use information from tax returns to renew my coverage.

If anyone on this application is eligible for Medicaid.

- I am assigning the Department of Human Services, my rights to payments for medical care from any third party, which may include but not limited to, other health insurance or legal settlement. I am also assigning the Department of Human Services, my rights to pursue and get medical support from a spouse or parent. I will cooperate in obtaining third party payments.
- Does any child on this application have a parent living outside of the home? ☐ **Yes** ☐ **No. If yes**, I understand I will be asked to cooperate with the Department of Human Services and the agency that collects medical support form an absent parent. If I think that cooperating to collect medical support will harm me or my children, I can tell Medicaid and I may not have to cooperate.
- I agree to cooperate with the Department of Human Services, Federal Quality Control reviewers or auditors if my case is selected for a review.

My right to appeal

If I think the Department of Human Services or the Hawaii Health Connector has made a mistake. I can appeal its decision. To appeal means to tell someone at the Department of Human Services or the Hawaii Health Connector that I think the action is wrong, and ask for a fair review of the action. I know that I can find out how to appeal by contacting someone at **1-877-628-5076**. I know that I can be represented in the process by someone other than myself. My eligibility and other information will be explained to me.

Sign this application. The person who filled out Step 1 should sign this application. If you're an authorized representative you may sign here with your name, as long as you have provided the information required in Appendix C.

Signature	Date (mm/dd/yyyy)

STEP 6 Mail your signed application to:

MQD/EB
Oahu Section
P.O. Box 3490
Honolulu, HI 96811-3490

MQD/EB
Kapolei Unit
P.O. Box 29920
Honolulu, HI 96820-2320

MQD/EB
East Hawaii Section
1404 Kilauea Avenue
Hilo, HI 96720

MQD/EB
West Hawaii Section
Lanihau Professional Center
75-5591 Palani Road, Suite 3004
Kailua-Kona HI 96740-3633

MQD/EB
Lanai Unit
P.O. Box 631374
Lanai City, HI 96793-0737

MQD/EB
Maui Section
Millyard Plaza
210 Imi Kala Street, Suite 101
Honolulu, HI 96820-2320

MQD/EB
Molokai Unit
P.O. Box 1619
Kaunakakai, HI 96748-1619

MQD/EB
Kauai Section
4473 Pahee Street, Suite A
Lihue, HI 96766

If you want to register to vote you can complete the attached voter registration from or download a form from **hawaii.gov/elections**.

TN NO: 13-007-MM7 **Approval Date** **November 18, 2015** **Effective Date: January 1, 2014**

NEED HELP WITH YOUR APPLICATION? Visit mybenefits.hawaii.gov or call us at 1-877-628-5076. If you need help in a language other than English, call 1-877-628-5076 and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY/TDD users should call 1-855-858-8604.

APPENDIX A

Health Coverage from Jobs

You DON'T need to answer these questions unless someone in the household is eligible for health coverage from a job. Attach a copy of this page for each job that offers coverage.

Tell us about the job that offers coverage
Take the Employer Coverage Tool on the next page to the employer who offers coverage to help you answer these questions. You only need to include this page when you send in your application, not the Employer Coverage Tool.

EMPLOYEE Information

The employee needs to fill out this section.

1. Employee name (First, Middle, Last)	2. Employee Social Security Number
	☐☐☐-☐☐-☐☐☐☐

EMPLOYER Information

Ask the employer for this section.

3. Employer name		4. Employer Identification Number (EIN)
5. Employer address (notice will be sent to this address)		6. Employer phone number ( ) –
7. City	8. State	9. Zip Code
10. Who can we contact about employee health at this job?		
11. Phone number (if different from above) ( ) –		12. Email address

13. Are you currently eligible for coverage offered by this employer, or will you become eligible in the next three (3) months?
☐ Yes (continue)
13a. If you're in a waiting or probationary period, when can you enroll in coverage? _____ mm/dd/yyyy
List the names of anyone else who is eligible for coverage from this job.
Name: Name: Name:
☐ No (STOP and go to Step 5 in the application)

Tell us about the health plan offered by this employer.

14. Does the employer offer a health plan that meets the minimum value standard*?
☐ **Yes** ☐ **No**

15. For the lowest-cost plan that meets the minimum value standard* offered only to the employee (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/she received the maximum discount for any tobacco cessation programs, and did not receive any other discounts based on wellness programs.
a. How much would the employee have to pay in premiums for this plan? $_____
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Once a month ☐ Quarterly ☐ Yearly

16. What change will the employer make for the new year (if known)?
☐ Employer won't offer health coverage.
☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.*(Premium should reflect the discount for wellness programs. See question 15)
a. How much will the employee have to pay in premiums for that plan? $_____
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Once a month ☐ Quarterly ☐ Yearly

Date of change (mm/dd/yyyy): _____

*An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit cost covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

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DHS 1100 Application for Health Coverage & Help Paying Costs

EMPLOYER COVERAGE TOOL

Use this tool to help answer questions in Appendix A about any employer health coverage that you're eligible for (even if it's from another person's job, like a parent or spouse). The information in the numbered boxes below match the boxes on Appendix A. For example, the answer to question 14 on this page should match question 14 on Appendix A.

Write your name and Social Security number in boxes 1 and 2 and ask the employer to fill out the rest of the form. Complete one tool for each employer that offers health coverage.

EMPLOYEE Information

The employee needs to fill out this section.

1. Employee name (First, Middle, Last)	2. Social Security Number
	☐☐☐-☐☐-☐☐☐☐

EMPLOYER Information

Ask the employer for this section.

3. Employer name		4. Employer Identification Number (EIN)
5. Employer address (notice will be sent to this address)		6. Employer phone number ( ) –
7. City	8. State	9. Zip Code
10. Who can we contact about employee health at this job?		
11. Phone number (if different from above) ( ) –	12. Email address	

13. Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next three (3) months?
- ☐ Yes (continue)
  - 13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage?
    _____ mm/dd/yyyy (Continue)
- ☐ No (**STOP** and return this form to employee)

Tell us about the health plan offered by this employer.

Does the employer offer a health plan that covers an employee's spouse or dependent?
☐ **Yes** Which people? ☐ Spouse ☐ Dependent(s)
☐ **No**

(Go to question 14)

14. Does the employer offer a health plan that meets the minimum value standard*?
☐ **Yes** (Go to question 15) ☐ **No** (**STOP** and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* offered only to the employee (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/she received the maximum discount for any tobacco cessation programs, and did not receive any other discounts based on wellness programs.
a. How much would the employee have to pay in premiums for this plan? $_____
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Once a month ☐ Quarterly ☐ Yearly

If the plan year will end soon and you know the health plans offered will change, go to question 16. If you don't know, **STOP** and return form to employee.

16. What change will the employer make for the new plan year?
- ☐ Employer won't offer health coverage.
- ☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.*(Premium should reflect the discount for wellness programs. See question 15)
  a. How much will the employee have to pay in premiums for that plan? $_____
  b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Once a month ☐ Quarterly ☐ Yearly

Date of change (mm/dd/yyyy): _____

*An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit cost covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

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APPENDIX B

American Indian or Alaska Native Family Member (AI/AN)

Complete this appendix if you or a family member are American Indian or Alaska Native. Submit this with your Application for Health Coverage & Help Paying Costs.

Tell us about your American Indian or Alaska Native family member(s).
American Indians and Alaska Natives can get services from the Indian Health Services, tribal health program, or urban Indian health programs. They also may not have to pay cost sharing and may get special monthly enrollment periods. Answer the following questions to make sure your family gets the most help possible.

NOTE: If you have more people to include, make a copy of this page and attach.

	AI/AN PERSON 1	AI/AN PERSON 2
1. Name (First name, Middle name, Last name)	First Middle Last	First Middle Last
2. Member of a federally recognized tribe?	☐ **Yes** If yes, tribe name is: ☐ **No**	☐ **Yes** If yes, tribe name is: ☐ **No**
3. Has this person ever gotten a service from the Indian Health Service, a tribal health program, or urban Indian health program, or through a referral from one of these programs?	☐ **Yes** ☐ **No. If no**, is this person eligible to get services from the Indian Health services, tribal health programs, or urban Indian health programs, or through a referral from one of these programs? ☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No. If no**, is this person eligible to get services from the Indian Health services, tribal health programs, or urban Indian health programs, or through a referral from one of these programs? ☐ **Yes** ☐ **No**
4. Certain money received may not be counted for Medicaid or the Children's Health Insurance Program (CHIP). List any income (amount and how often) reported on your application that includes money from these sources: • Per capita payments from a tribe that come from natural resources, usage rights, leases, or royalties. • Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior (including reservations and former reservations). • Money from selling things that have cultural significance.	$_____ How often?_____	$_____ How often?_____

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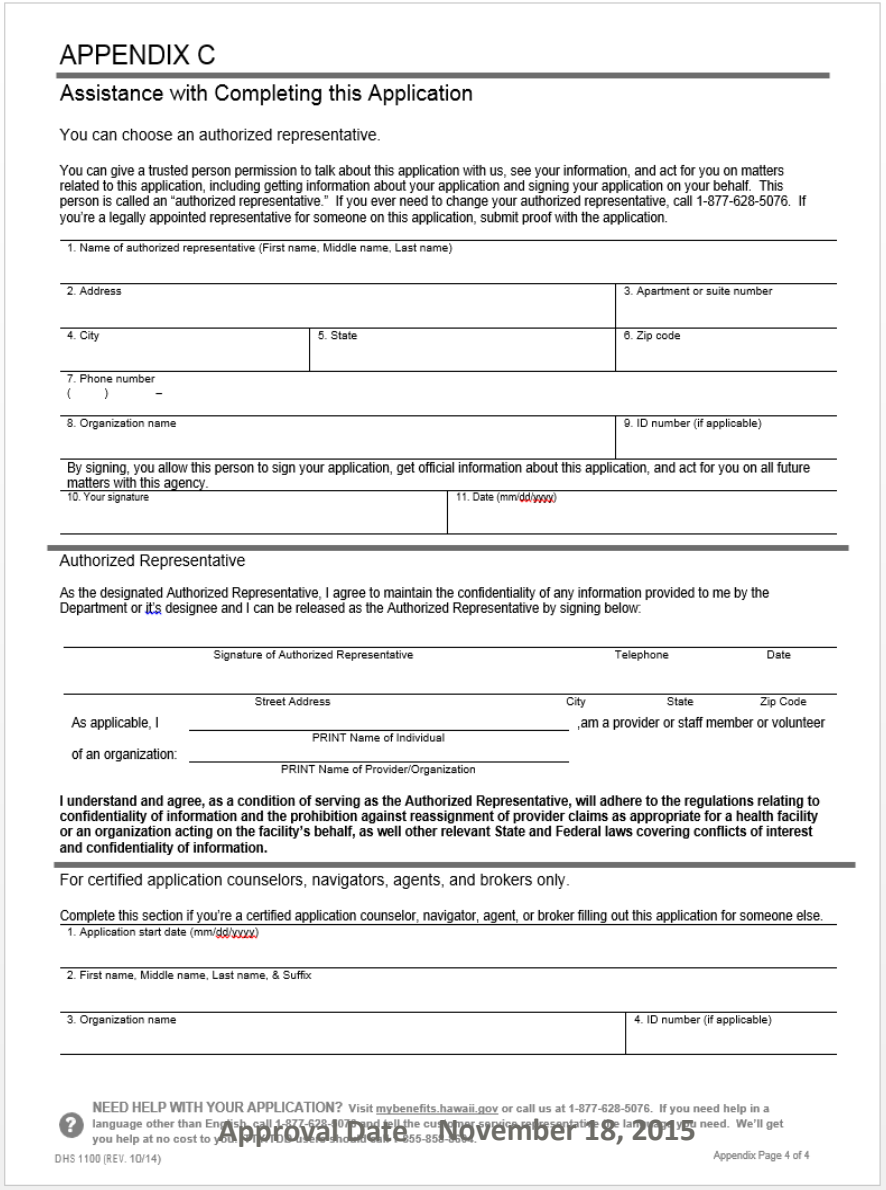
DHS 1100 Application for Health Coverage & Help Paying Costs



APPENDIX C

Assistance with Completing this Application

You can choose an authorized representative.

You can give a trusted person permission to talk about this application with us, see your information, and act for you on matters related to this application, including getting information about your application and signing your application on your behalf. This person is called an "authorized representative." If you ever need to change your authorized representative, call 1-877-628-5076. If you're a legally appointed representative for someone on this application, submit proof with the application.

1. Name of authorized representative (First name, Middle name, Last name)

2. Address | 3. Apartment or suite number

4. City | 5. State | 6. Zip code

7. Phone number
( ) –

8. Organization name | 9. ID number (if applicable)

By signing, you allow this person to sign your application, get official information about this application, and act for you on all future matters with this agency.

10. Your signature | 11. Date (mm/dd/yyyy)

Authorized Representative

As the designated Authorized Representative, I agree to maintain the confidentiality of any information provided to me by the Department or its designee and I can be released as the Authorized Representative by signing below:

Signature of Authorized Representative | Telephone | Date

Street Address | City | State | Zip Code

As applicable, I _____ ,am a provider or staff member or volunteer
PRINT Name of Individual

of an organization: _____
PRINT Name of Provider/Organization

I understand and agree, as a condition of serving as the Authorized Representative, will adhere to the regulations relating to confidentiality of information and the prohibition against reassignment of provider claims as appropriate for a health facility or an organization acting on the facility's behalf, as well other relevant State and Federal laws covering conflicts of interest and confidentiality of information.

For certified application counselors, navigators, agents, and brokers only.

Complete this section if you're a certified application counselor, navigator, agent, or broker filling out this application for someone else.

1. Application start date (mm/dd/yyyy)

2. First name, Middle name, Last name, & Suffix

3. Organization name | 4. ID number (if applicable)

NEED HELP WITH YOUR APPLICATION? Visit mybenefits.hawaii.gov or call us at 1-877-628-5076. If you need help in a language other than English, call 1-877-628-5076 and tell the customer service representative the language you need. We'll get you help at no cost to you. [illegible] should call 1-855-889-5004.

DHS 1100 (REV. 10/14) Appendix Page 4 of 4

Med-QUEST Responsibilities

Upon receipt of the HPE packet sent by the participating hospital, the Med-QUEST office shall:

- Log receipt of HPE packet and input information from HPE application and decision notice into the KOLEA system within 48 hours of receipt;
- Review DHS 1100 and determine eligibility for regular Medicaid or pend for verifications if needed;
- Upon receipt of required verifications, complete eligibility determination for regular Medicaid.
- Send appropriate Medicaid approval or denial notice to HPE beneficiary and a copy to HPE hospital staff who submitted the HPE packet
- Terminate HPE benefits pursuant to hospital PE period from date the eligibility determination for regular Medicaid is determined.
- If an HPE application is received with no DHS 1100 attached, input information in KOLEA, and terminate HPE effective the last day of the month following the month of HPE application.

Connecting to Full Medicaid Coverage Outside the Hospital

Individuals can also apply for full Medicaid coverage as follows:

- Online at mybenefits.Hawaii.gov or by calling 1-877-628-5076;
- In-person at the nearest Med-QUEST Eligibility Branch office;
- By mailing the paper application to the Med-QUEST Eligibility Branch office closest to their home;
- By faxing the paper application to 587-3543; or
- By calling Medicaid customer service on Oahu: 524-3370 , TDD: 692-7182, Neighbor Islands : 1-800-316-8005, TDD: 1-800-603-1201

Contact Information

For questions or more information on Hawaii's Hospital Presumptive Eligibility policies, providers may contact:

Policy and Program Development Office

Phone: 808-692-8058, Fax: 808-692-8173

Information is also available on the Department's website:

www.Med-QUEST.us- Program information