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State/Territory Name: Hawaii

State Plan Amendment (SPA) #: 14-0008

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

February 17, 2015

Rachel Wong, DrPH
Director, Department of Human Services
P.O. Box 339
Honolulu, HI 96809-0339

Dear Dr. Wong:

Enclosed is an approved copy of Hawaii's State Plan Amendment (SPA) 14-0008, which was submitted to CMS on November 20, 2014. SPA 14-0008 incorporates the MAGI-based eligibility process requirements, including the single streamlined application, into Hawaii's approved Medicaid State Plan in accordance with the Affordable Care Act. The effective date of this SPA is October 1, 2014.

The approval of SPA 14-0008 includes full approval of your state's alternative single streamlined paper and online application. Enclosed is a copy of the new State Plan pages and attachments to be incorporated within a separate section at the end of Hawaii's approved State Plan:

- S94, pages S94-1 and S94-2
- Alternative single, streamlined paper application, pages 1-13
- Alternative single, streamlined online application, pages 1-17

If you have any questions concerning this SPA, please contact Christy Bonstelle at 415-744-3522, or by e-mail at Christy.Bonstelle@cms.hhs.gov.

Sincerely,

/s/

Hye Sun Lee
Acting Associate Regional Administrator
Division of Medicaid & Children's Health Operations

cc: Kenny Fink, Med-QUEST Administrator
Tom Duran, CMS Pacific Area Representative

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-14-0008

Proposed Effective Date

10/01/2014 *(mm/dd/yyyy)*

Federal Statute/Regulation Citation

42 C.F.R. 435, Subparts J and M

Federal Budget Impact

	Federal Fiscal Year	Amount
First Year	2015	$ 0.00
Second Year	2016	$ 0.00

Subject of Amendment

The proposed amendment shall revise Hawaii's application for financial assistance with health insurance (i.e., Medicaid and Advance Premium Tax Credits). The revisions simplify and clarify certain questions, which are expected to result in more accurate completion of applications, decreased need to request supplemental information, and overall improved time from application submission to eligibility determination.

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 Director of Human Services

Signature of State Agency Official

Submitted By:	**Aileen Befitel**
Last Revision Date:	**Feb 13, 2015**
Submit Date:	**Nov 20, 2014**

Medicaid Eligibility

State Name: Hawaii

OMB Control Number: 0938-1148

Transmittal Number: 14 - - 0008

Expiration date: 10/31/2014

General Eligibility Requirements
Eligibility Process

S94

42 CFR 435, Subpart J and Subpart M

Eligibility Process

☑ The state meets all the requirements of 42 CFR 435, Subpart J for processing applications, determining and verifying eligibility, and furnishing Medicaid.

Application Processing

Indicate which application the agency uses for individuals applying for coverage who may be eligible based on the applicable modified adjusted gross income standard.

☐ The single, streamlined application for all insurance affordability programs, developed by the Secretary in accordance with section 1413(b)(1)(A) of the Affordable Care Act

☒ An alternative single, streamlined application developed by the state in accordance with section 1413(b)(1)(B) of the Affordable Care Act and approved by the Secretary, which may be no more burdensome than the streamlined application developed by the Secretary.

An attachment is submitted.

☐ An alternative application used to apply for multiple human service programs approved by the Secretary, provided that the agency makes readily available the single or alternative application used only for insurance affordability programs to individuals seeking assistance only through such programs.

An attachment is submitted.

Indicate which application the agency uses for individuals applying for coverage who may be eligible on a basis other than the applicable modified adjusted gross income standard:

☐ The single, streamlined application developed by the Secretary or one of the alternate forms developed by the state and approved by the Secretary, and supplemental forms to collect additional information needed to determine eligibility on such other basis, submitted to the Secretary.

An attachment is submitted.

☒ An application designed specifically to determine eligibility on a basis other than the applicable MAGI standard which minimizes the burden on applicants, submitted to the Secretary.

An attachment is submitted.

The agency's procedures permit an individual, or authorized person acting on behalf of the individual, to submit an application via the internet website described in 42 CFR 435.1200(f), by telephone, via mail, and in person.

The agency also accepts applications by other electronic means:

◉ Yes ○ No

Indicate the other electronic means below:

	Name of Method	Description	
+	Facsimile	The agency accepts applications received via facsimile.	X
+	E-mail	The agency accepts applications received via e-mail.	X

☑ The agency has procedures to take applications, assist applicants and perform initial processing of applications for the eligibility groups listed below at locations other than those used for the receipt and processing of applications for the title IV-A program, including Federally-qualified health centers and disproportionate share hospitals.

Parents and Other Caretaker Relatives

Pregnant Women

Infants and Children under Age 19

Redetermination Processing

☑ Redeterminations of eligibility for individuals whose financial eligibility is based on the applicable modified adjusted gross income standard are performed as follows, consistent with 42 CFR 435.916:

■ Once every 12 months

■ Without requiring information from the individual if able to do so based on reliable information contained in the individual's account or other more current information available to the agency

■ If the agency cannot determine eligibility solely on the basis of the information available to it, or otherwise needs additional information to complete the redetermination, it provides the individual with a pre-populated renewal form containing the information already available.

■ Redeterminations of eligibility for individuals whose financial eligibility is not based on the applicable modified adjusted gross income standard are performed, consistent with 42 CFR 435.916 (check all that apply):

☒ Once every 12 months

☐ Once every 6 months

☐ Other, more often than once every 12 months

Coordination of Eligibility and Enrollment

☑ The state meets all the requirements of 42 CFR 435, Subpart M relative to coordination of eligibility and enrollment between Medicaid, CHIP, Exchanges and other insurance affordability programs. The single state agency has entered into agreements with the Exchange and with other agencies administering insurance affordability programs.

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**.

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，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- 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 umawayg iti 1-888-764-7586 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 １－８８８－７６４－７５８６ 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 1-888 - 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 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 1-888-764-7586 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 serbisio 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 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 1-888-764-7586 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**

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 your 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 gets 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 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 or in the community ☐ No
   b. Have you received long term care nursing services in the last three (3) months? ☐ **Yes** ☐ **No** If yes, what date(s)? _____
   c. Do you think you need long term care nursing services now? ☐ Yes ☐ No
   d. Do you receive Supplemental Security Income (SSI)? ☐ Yes ☐ No

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

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 _____

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.

Not employed
Skip to question 28.

Self-employed
Skip to question 27.

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 (profits once 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 copy (ies) of STEP 2: PERSON 2 (Pages 4 and 5) and Complete.

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 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 or in the community ☐ No
b. Has PERSON 2 received long term care services in the last three (3) months? ☐ Yes ☐ No If yes, what date(s)? _____
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 application?
☐ Yes ☐ No If yes, what date(s)? _____

12. Is PERSON 2 a U.S. citizen or U.S. national? ☐ Yes If yes, skip to question 13. ☐ 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 States 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.

STEP 2: PERSON 2

Current Job & Income Information

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

Not employed
Skip to question 29.

Self-employed
Skip to question 28.

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 (profits once business expenses are paid) will you get from 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 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 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 expect 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 to Step 4.

STEP 4 Your Family's Health Coverage

Answer these questions for anyone who needs 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 Corps _____

☐ 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 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 0938-1191. 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 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.

STEP 5 Read & 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 that 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 **1-877-628-5076** 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 and 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 you to 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 year 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 from 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
88 Kanoelehua Ave.
Hilo, HI 96720-4670

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 96763-0737

MQD/EB-Maui Section
Millyard Plaza
210 Imi Kala Street, Suite 101
Wailuku, HI 96793-1274

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

MQD/EB-Kauai Section
4473 Pahee Street, Suite A
Lihue, HI 96766-2037

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

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

1. Employee name (First, Middle, Last)

2. Employee Social Security number
☐☐☐ - ☐☐ - ☐☐☐☐

EMPLOYER Information

3. Employer name		4. Employer Identification Number (EIN) _____ - _____
5. Employer address		6. Employer phone number ( ) –
7. City	8. State	9. ZIP code
10. Who can we contact about employee health coverage 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 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 here 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 plan 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 costs 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)

EMPLOYER COVERAGE TOOL

Form Approved
OMB No. 0938-1191

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 information.

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 coverage 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 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 didn't 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 that 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 costs 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)

APPENDIX B

Form Approved
OMB No. 0938-1191

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 programs, 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 No	Yes If yes, tribe name 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 Service, 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 Service, 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?_____

APPENDIX C

Form Approved
OMB No. 0938-1191

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 it's 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 of an
PRINT Name of Individual

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 as 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 somebody else.

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

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

3. Organization name

4. ID number (if applicable)

3.2. UC-APP-002 Application Intake

Screen Flow

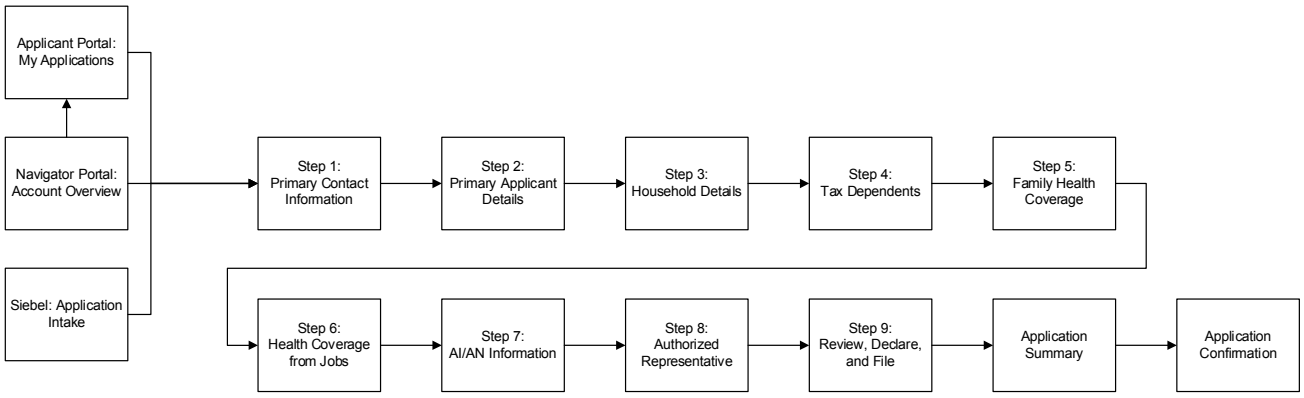

Figure 4 – Application Intake Screen Flow

Wireframe: Step 1: Primary Contact Information

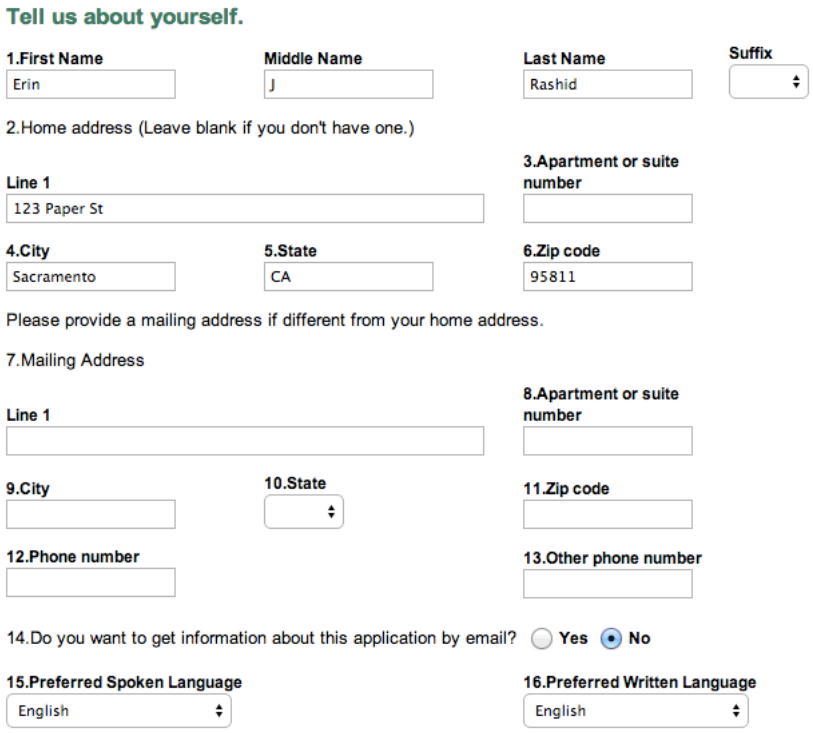

Figure 5 – Primary Contact Information Wireframe

Wireframe: Step 2: Primary Applicant Details

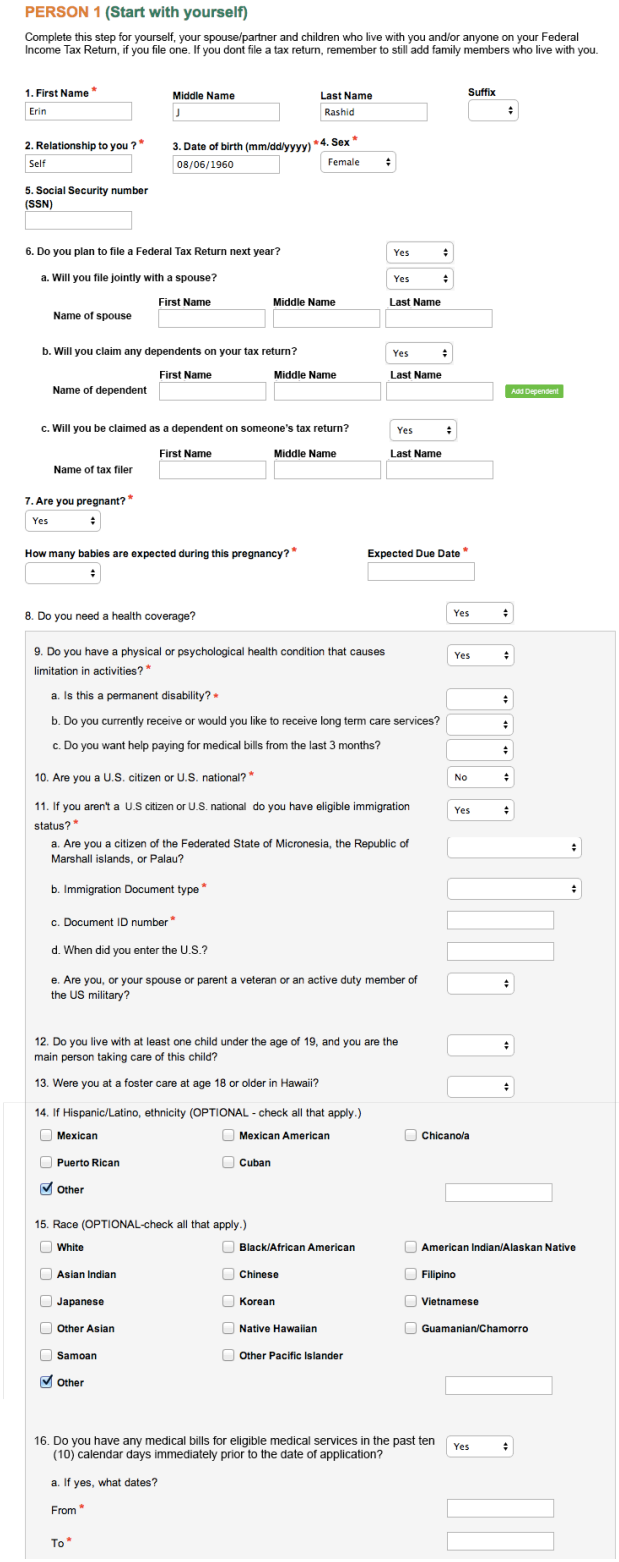

Figure 6 – Primary Applicant Details Wireframe (Part 1)

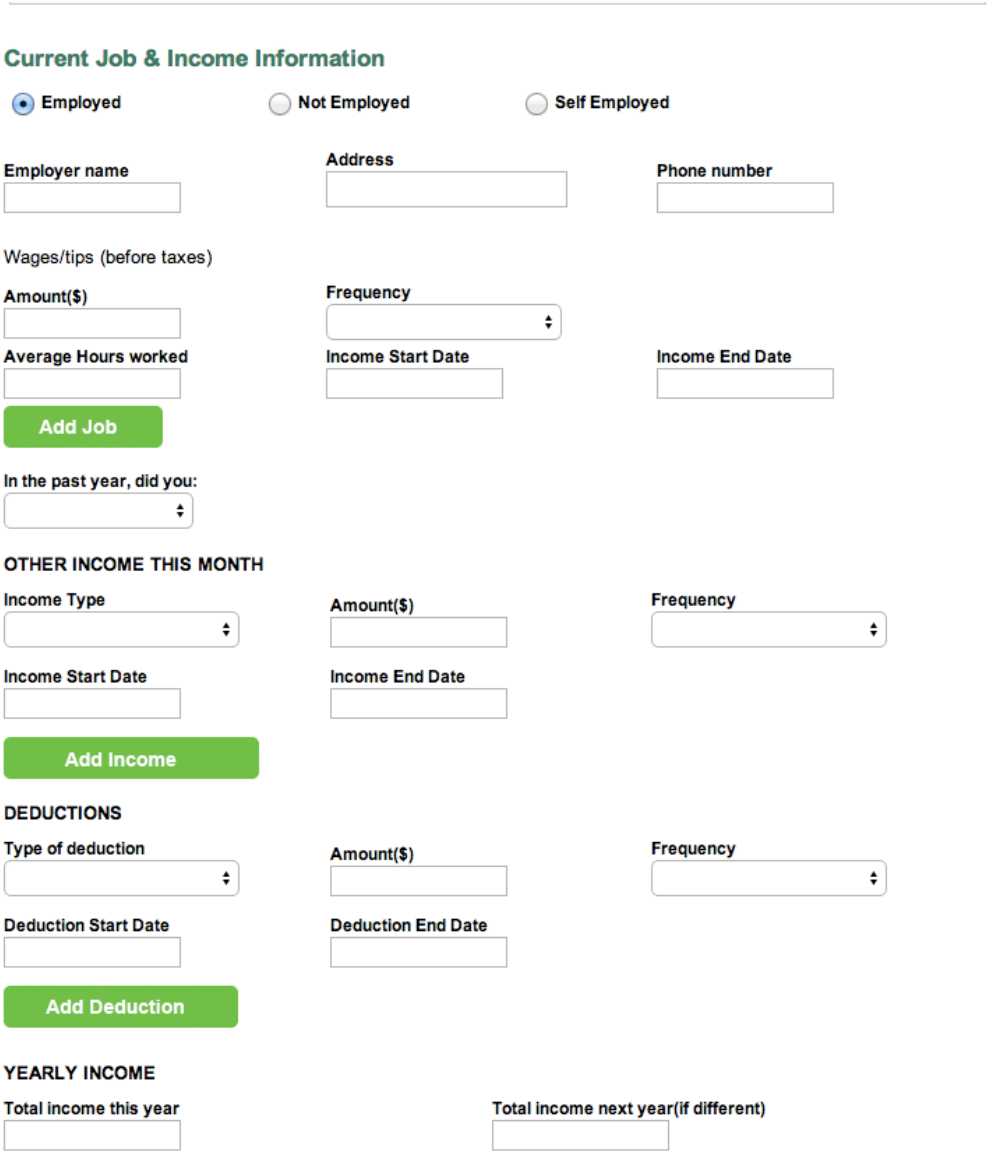

Figure 7 – Primary Applicant Details Wireframe (Part 2)

Wireframe: Step 3: Household Details

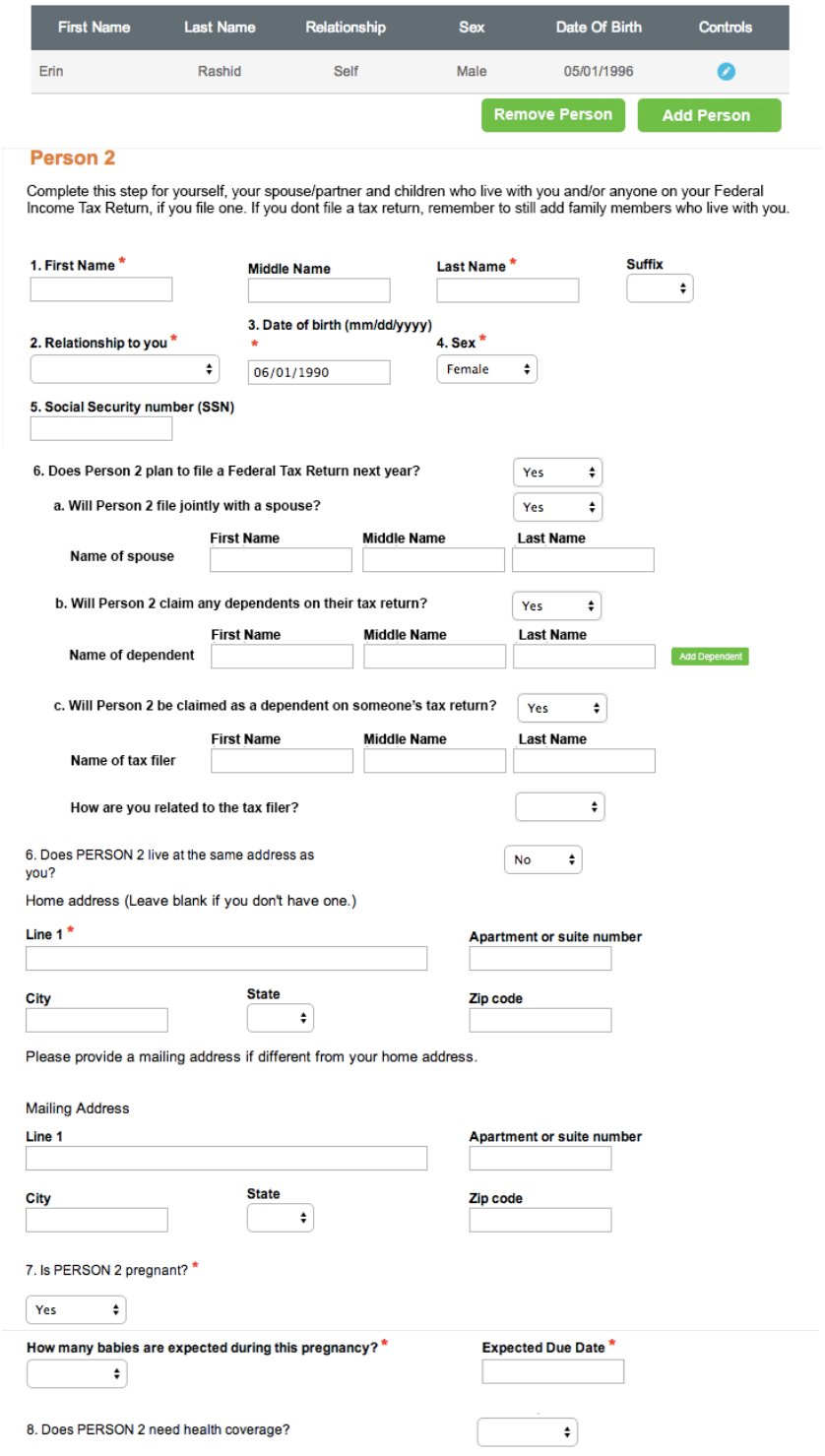

Figure 8 – Household Details Wireframe (Part 1)

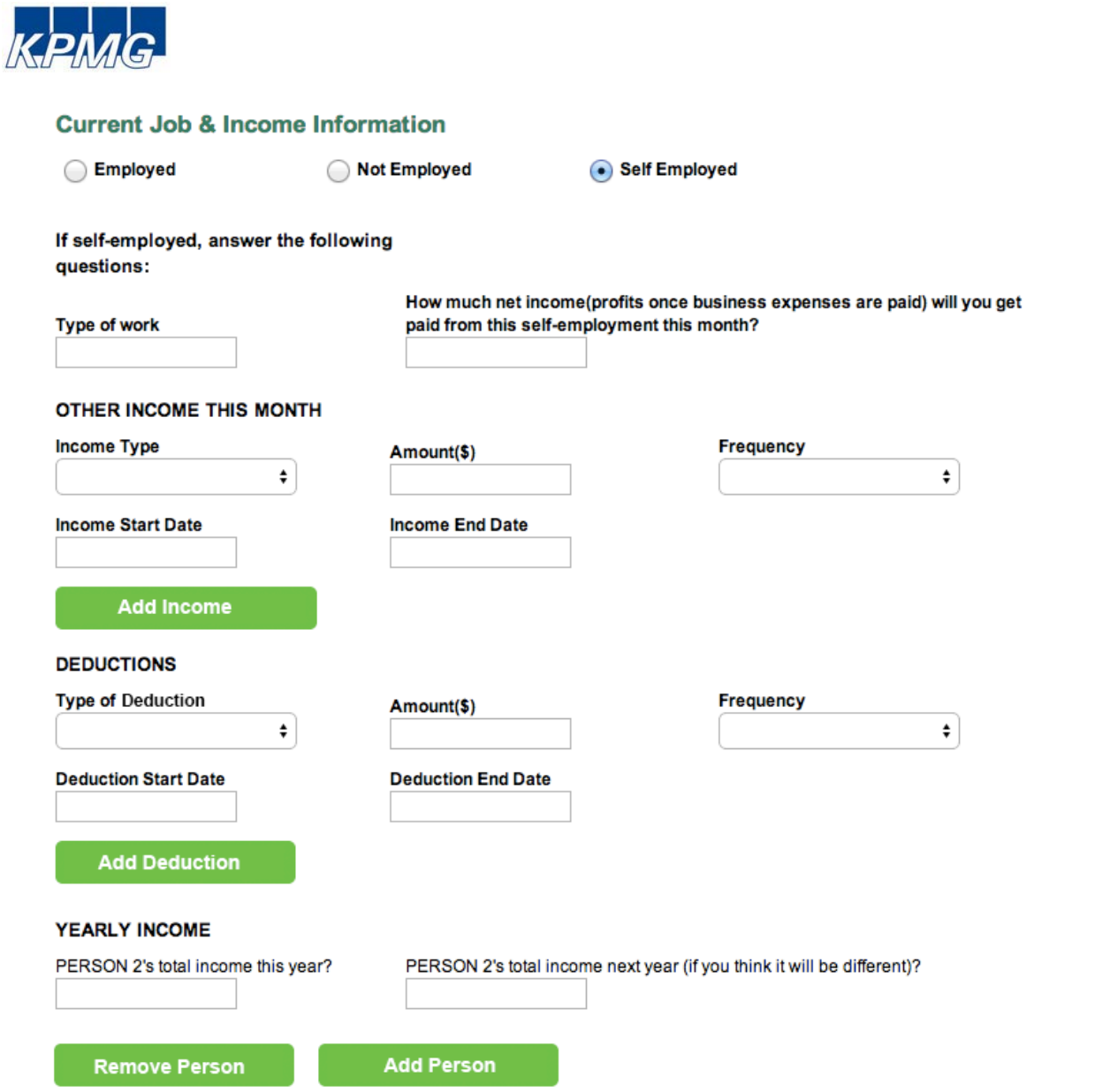

Figure 9– Household Details Wireframe (Part 2)

Wireframe: Step 4: Tax Dependents

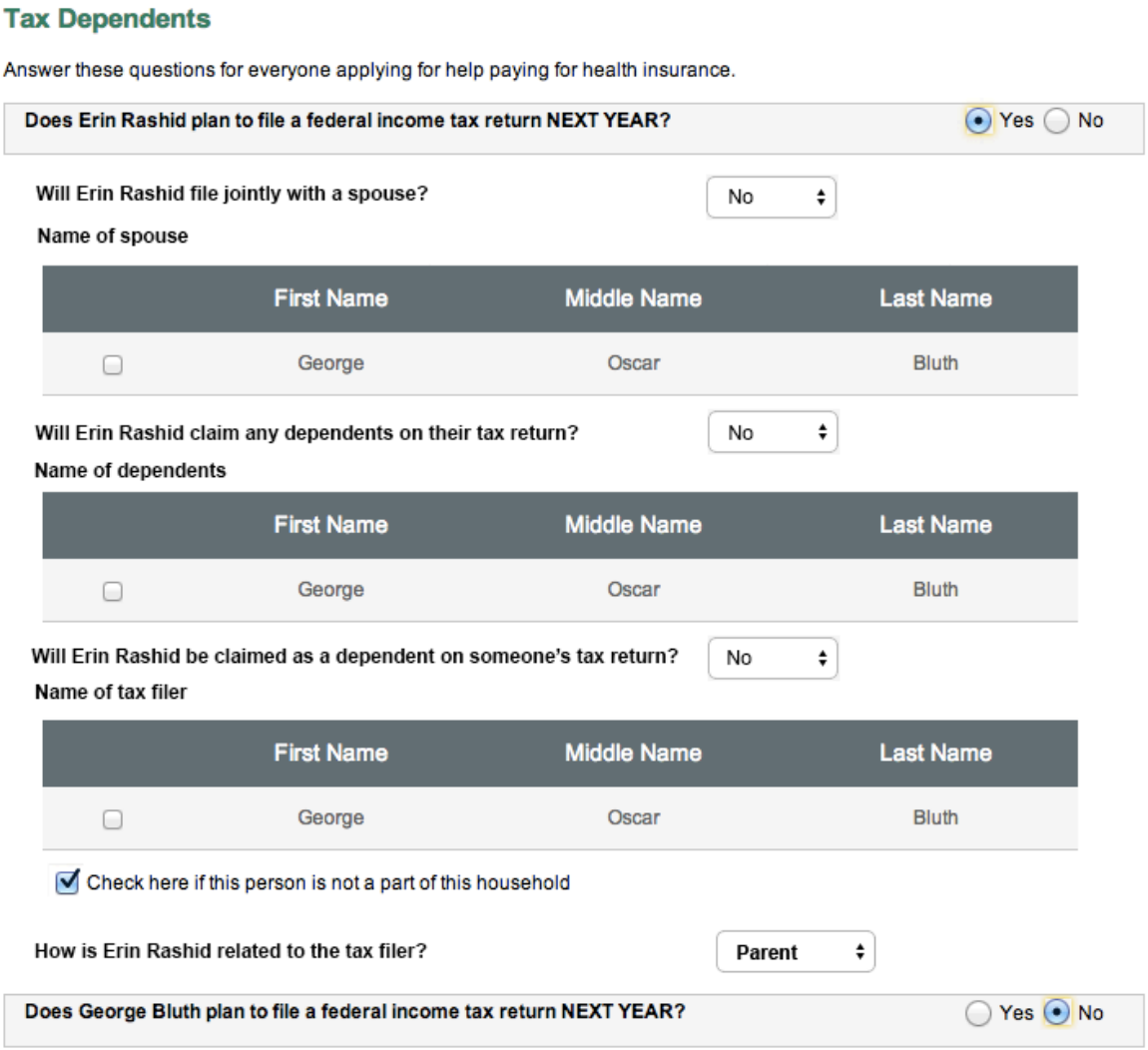

Figure 10 – Tax Dependents Wireframe

- This screen will be pre-populated with information gathered from Steps 2 and 3.
- The application will pre-populate each of the household member checkbox lists by matching the name provided by the User during Steps 2 and 3.
- It is assumed that if the User's spelling of the name of a spouse, dependent, or tax filer does not match one of the household member(s) names, the System will not be able to pre-populate the checkbox list. The User must select the household member(s) from the list in this scenario.

Wireframe: Step 5: Family Health Coverage

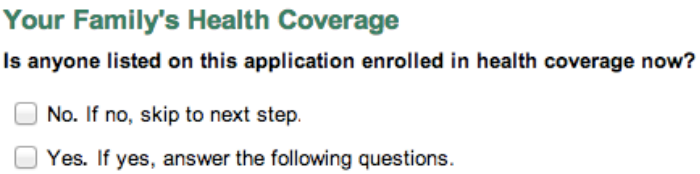

Figure 11 – Family Health Coverage Wireframe (Page Load)

Figure 12 – Family Health Coverage Wireframe (Collapsed)

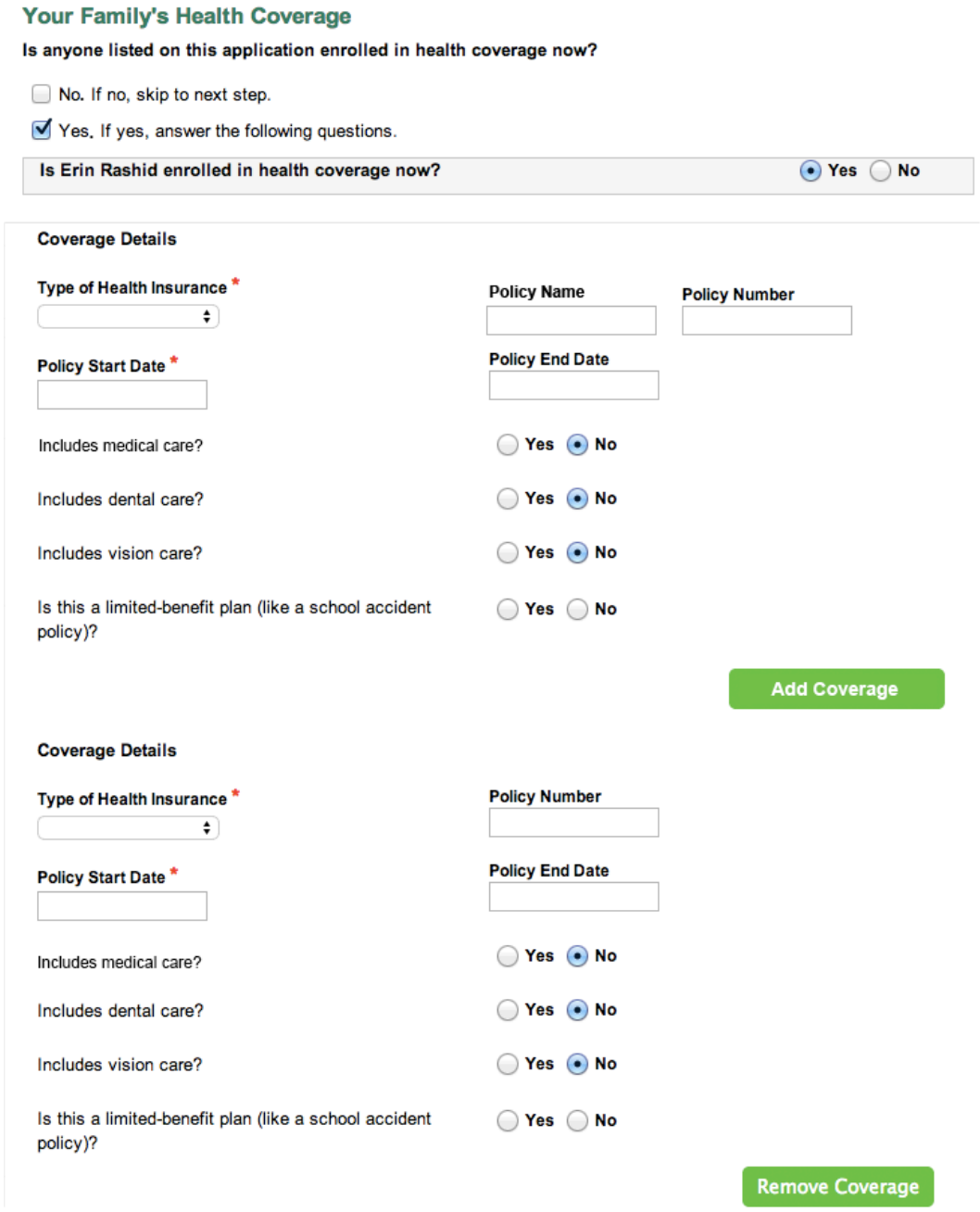

Figure 13 – Family Health Coverage Wireframe (Expanded)

Wireframe: Step 6: Health Coverage from Jobs

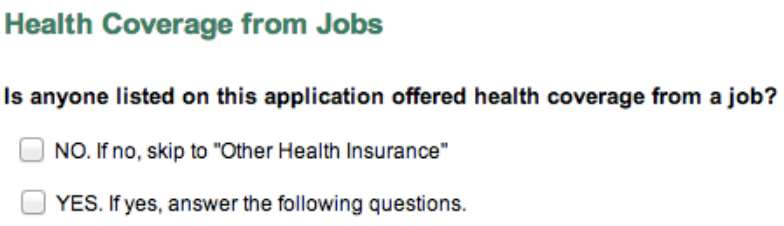

Figure 14 – Health Coverage from Jobs Wireframe (Page Load)

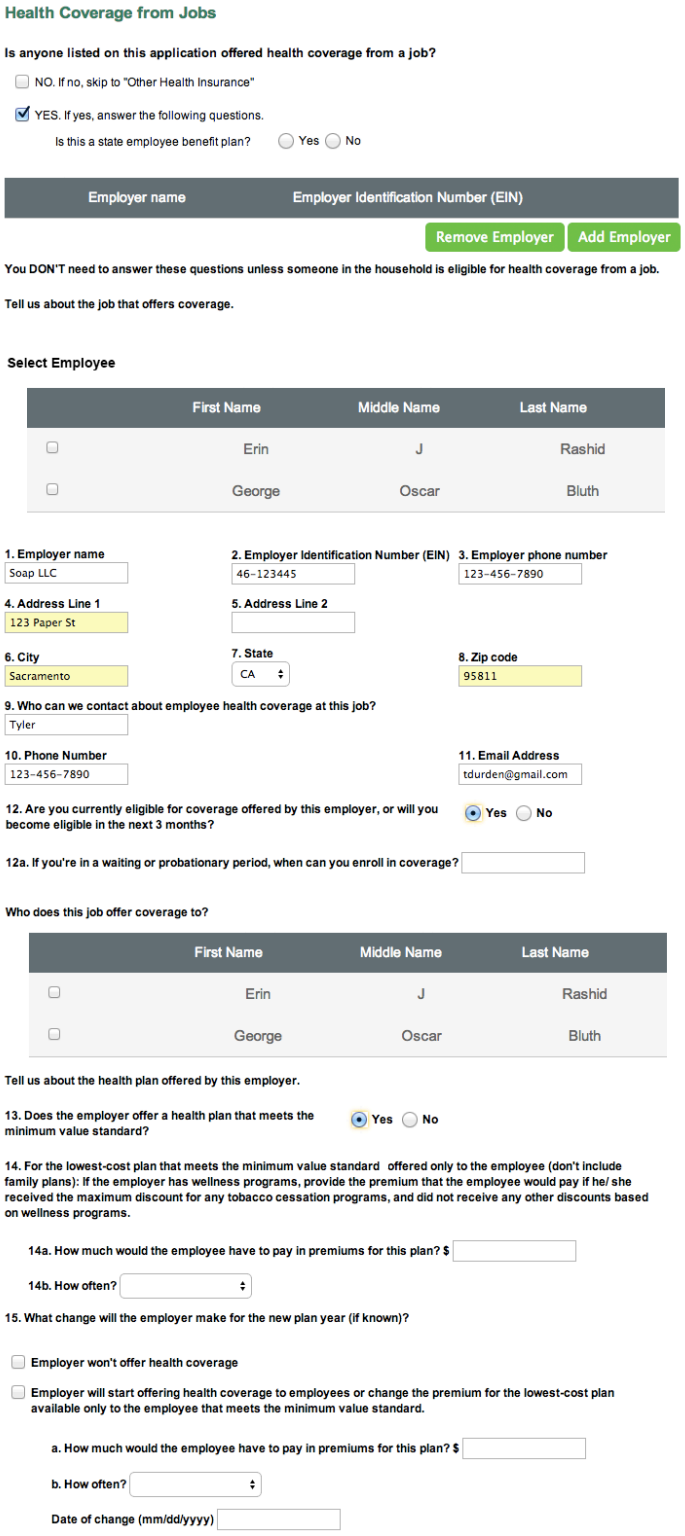

Figure 15 – Health Coverage from Jobs Wireframe (Expanded)

Wireframe: Step 7: American Indian/Alaska Native Information

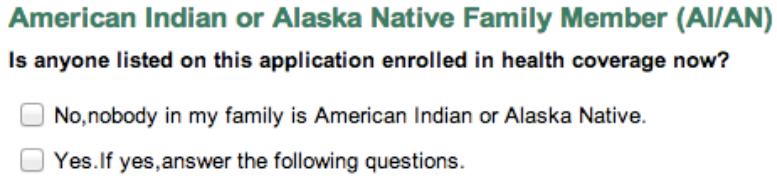

Figure 16 – American Indian/Alaska Native ("AI/AN") Information Wireframe (Page Load)

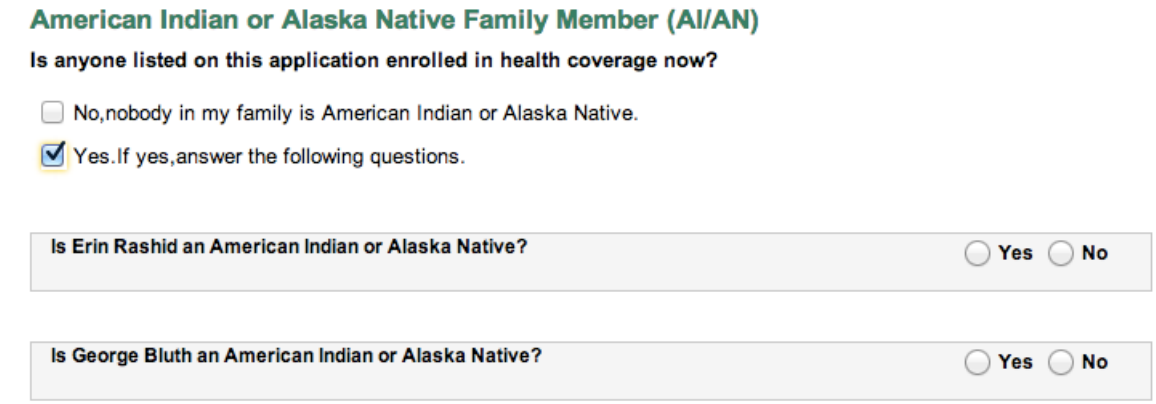

Figure 17 – AI/AN Information Wireframe (Collapsed)

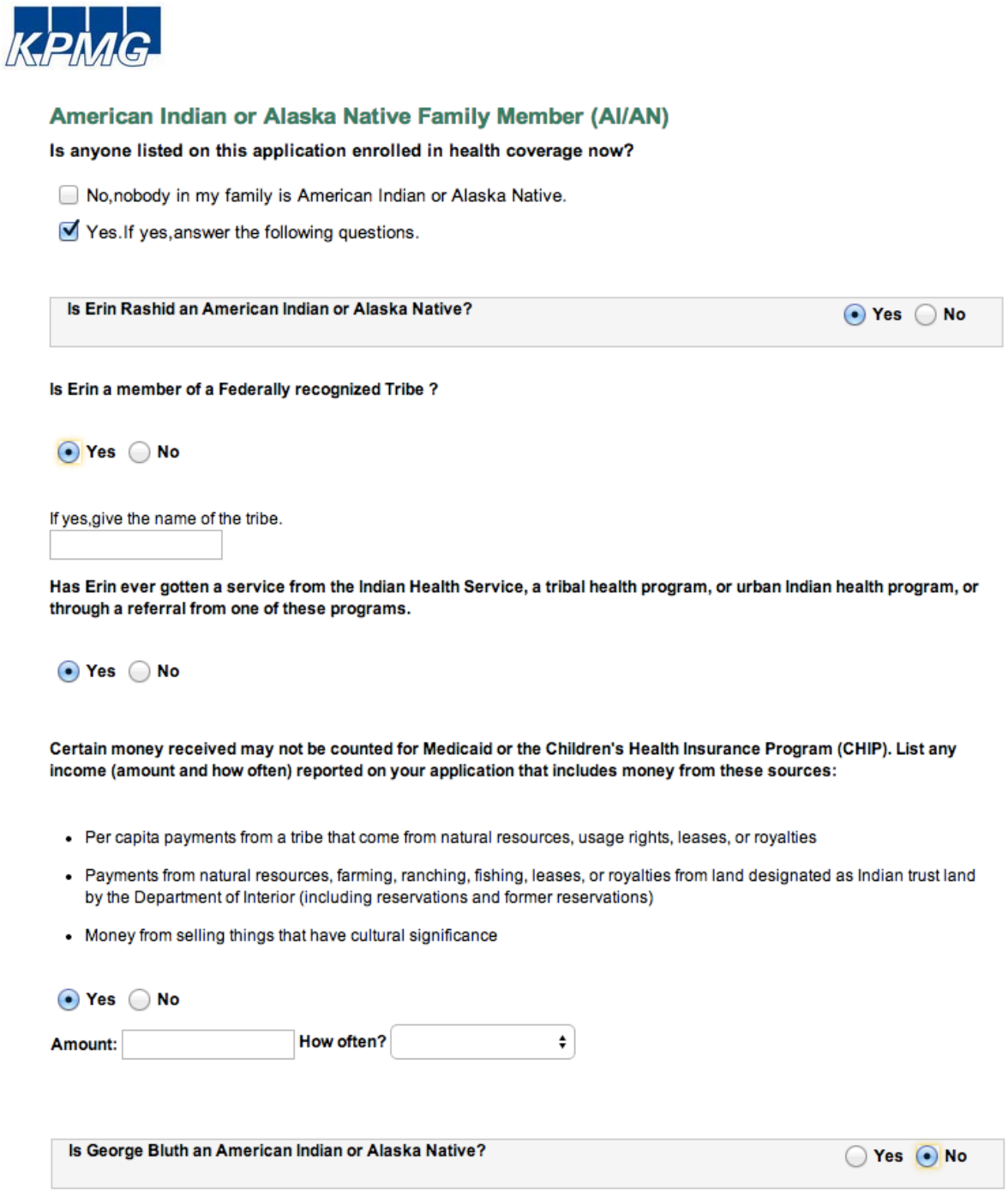

Figure 18 – AI/AN Information Wireframe (Expanded)

Wireframe: Step 8: Authorized Representative

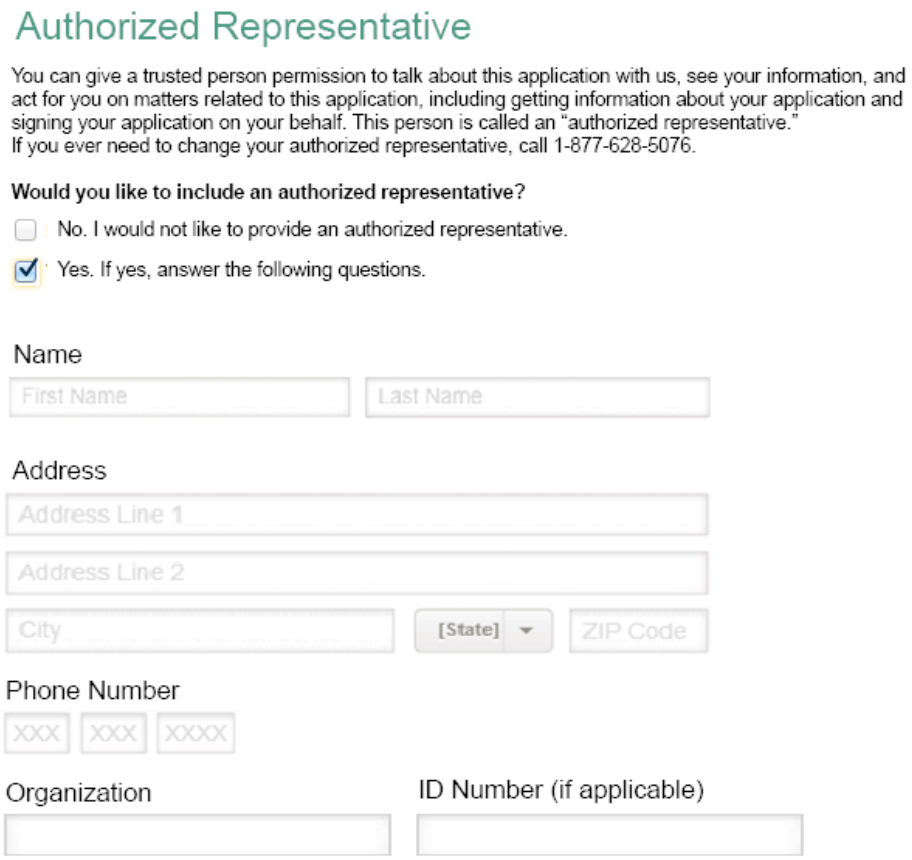

Figure 19 – Authorized Representative Wireframe

Wireframe: Step 9: Review, Declare, and File

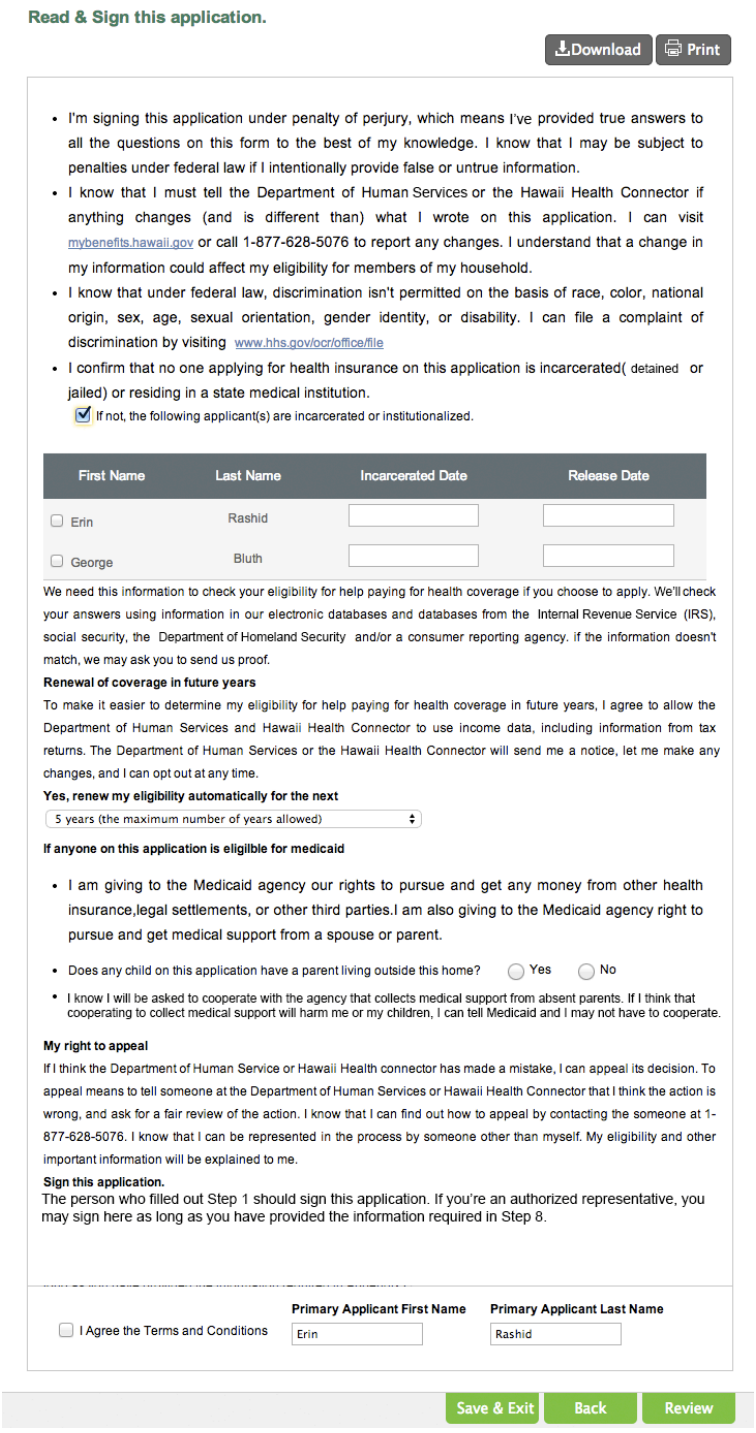

Figure 20 – Review, Declare, and File Wireframe

Wireframe: Application Summary

Figure 21 – Application Summary Wireframe

Wireframe: Application Confirmation

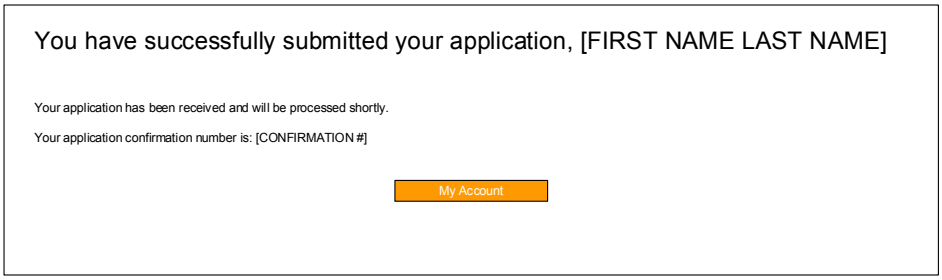

Figure 22 – Application Confirmation Wireframe