

Medical
Assistance
Application

Date Received by DHS

OFFICIAL USE ONLY
Organization Assisting with Application

Case Name

Case Number

Worker's Name

Section/Unit/EW Code

FS/HQ Combo Medical Only Upfront AF/GA

FOR CHILDREN AND PREGNANT WOMEN ONLY

This form should be completed only if you are requesting medical assistance for children 0 through 18 years old and/or pregnant women. If you need medical assistance for adults 19 years old and older who are not pregnant, please use Form 1100.

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

Last Name	First Name	Middle Initial	Best Phone Number to Call	Email Address
Address (Where you live)		Apartment Number	City, State, and Zip Code	
Mailing Address (If it is different from where you live)			What Language Do You Speak Best?	

2. Please check YES or NO for each question below. If you check YES, please complete.

YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	A. Is anyone who wants medical assistance pregnant? <i>(Unborn children may be counted in determining the pregnant woman's household size.)</i> Name _____ Due Date _____ Number of children expected _____
<input type="checkbox"/>	<input type="checkbox"/>	B. Was the pregnancy confirmed by a home pregnancy test or health care provider? <i>(If your answer is NO, we will request verification.)</i>
<input type="checkbox"/>	<input type="checkbox"/>	C. Is anyone who wants medical assistance 18-20 years old and claimed as a tax dependent? <i>(The tax dependent's parents' or legal guardians' income is counted for the QUEST program.)</i> Name _____
<input type="checkbox"/>	<input type="checkbox"/>	D. Is anyone self-employed? <i>(You may be eligible for self-employment deductions.)</i> Name _____
<input type="checkbox"/>	<input type="checkbox"/>	E. Is anyone blind or disabled? <i>(You may receive certain income deductions and help with unpaid medical bills.)</i> Name _____

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

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

<p>A. Last Name _____</p> <p>First Name _____</p> <p>Middle Initial _____</p> <p style="text-align: center;">Month Day Year</p> <p>Date of Birth _____ / _____ / _____</p> <p>Age _____</p> <p>SOCIAL SECURITY NUMBER (optional for non-applicants) _____</p>	<p>Wants Medical Assistance</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p> <p>Sex</p> <p><input type="checkbox"/> Male</p> <p><input type="checkbox"/> Female</p>	<p>Relationship to You</p> <p><input type="checkbox"/> Self</p> <p><input type="checkbox"/> Spouse</p> <p><input type="checkbox"/> Child</p> <p><input type="checkbox"/> Stepchild</p> <p><input type="checkbox"/> Other (specify): _____</p>	<p>Marital Status</p> <p><input type="checkbox"/> Single</p> <p><input type="checkbox"/> Married</p> <p><input type="checkbox"/> Separated</p> <p><input type="checkbox"/> Divorced</p> <p><input type="checkbox"/> Widowed</p>	<p>Citizenship (optional for non-applicants)</p> <p><input type="checkbox"/> U.S. or U.S. National</p> <p><input type="checkbox"/> CFA Individual</p> <p><input type="checkbox"/> Lawful Permanent Resident</p> <p>Entry Date: _____</p> <p><input type="checkbox"/> Other (specify): _____</p>	<p>Ethnicity (optional)</p> <p><input type="checkbox"/> Caucasian</p> <p><input type="checkbox"/> Chinese</p> <p><input type="checkbox"/> Filipino</p> <p><input type="checkbox"/> Hawaiian</p> <p><input type="checkbox"/> Japanese</p> <p><input type="checkbox"/> Other (specify): _____</p>
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<p>B. Last Name _____</p> <p>First Name _____</p> <p>Middle Initial _____</p> <p style="text-align: center;">Month Day Year</p> <p>Date of Birth _____ / _____ / _____</p> <p>Age _____</p> <p>SOCIAL SECURITY NUMBER (optional for non-applicants) _____</p>	<p>Wants Medical Assistance</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p> <p>Sex</p> <p><input type="checkbox"/> Male</p> <p><input type="checkbox"/> Female</p>	<p>Relationship to You</p> <p><input type="checkbox"/> Self</p> <p><input type="checkbox"/> Spouse</p> <p><input type="checkbox"/> Child</p> <p><input type="checkbox"/> Stepchild</p> <p><input type="checkbox"/> Other (specify): _____</p>	<p>Marital Status</p> <p><input type="checkbox"/> Single</p> <p><input type="checkbox"/> Married</p> <p><input type="checkbox"/> Separated</p> <p><input type="checkbox"/> Divorced</p> <p><input type="checkbox"/> Widowed</p>	<p>Citizenship (optional for non-applicants)</p> <p><input type="checkbox"/> U.S. or U.S. National</p> <p><input type="checkbox"/> CFA Individual</p> <p><input type="checkbox"/> Lawful Permanent Resident</p> <p>Entry Date: _____</p> <p><input type="checkbox"/> Other (specify): _____</p>	<p>Ethnicity (optional)</p> <p><input type="checkbox"/> Caucasian</p> <p><input type="checkbox"/> Chinese</p> <p><input type="checkbox"/> Filipino</p> <p><input type="checkbox"/> Hawaiian</p> <p><input type="checkbox"/> Japanese</p> <p><input type="checkbox"/> Other (specify): _____</p>
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<p>C. Last Name _____</p> <p>First Name _____</p> <p>Middle Initial _____</p> <p style="text-align: center;">Month Day Year</p> <p>Date of Birth _____ / _____ / _____</p> <p>Age _____</p> <p>SOCIAL SECURITY NUMBER (optional for non-applicants) _____</p>	<p>Wants Medical Assistance</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p> <p>Sex</p> <p><input type="checkbox"/> Male</p> <p><input type="checkbox"/> Female</p>	<p>Relationship to You</p> <p><input type="checkbox"/> Self</p> <p><input type="checkbox"/> Spouse</p> <p><input type="checkbox"/> Child</p> <p><input type="checkbox"/> Stepchild</p> <p><input type="checkbox"/> Other (specify): _____</p>	<p>Marital Status</p> <p><input type="checkbox"/> Single</p> <p><input type="checkbox"/> Married</p> <p><input type="checkbox"/> Separated</p> <p><input type="checkbox"/> Divorced</p> <p><input type="checkbox"/> Widowed</p>	<p>Citizenship (optional for non-applicants)</p> <p><input type="checkbox"/> U.S. or U.S. National</p> <p><input type="checkbox"/> CFA Individual</p> <p><input type="checkbox"/> Lawful Permanent Resident</p> <p>Entry Date: _____</p> <p><input type="checkbox"/> Other (specify): _____</p>	<p>Ethnicity (optional)</p> <p><input type="checkbox"/> Caucasian</p> <p><input type="checkbox"/> Chinese</p> <p><input type="checkbox"/> Filipino</p> <p><input type="checkbox"/> Hawaiian</p> <p><input type="checkbox"/> Japanese</p> <p><input type="checkbox"/> Other (specify): _____</p>
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<p>D. Last Name _____</p> <p>First Name _____</p> <p>Middle Initial _____</p> <p style="text-align: center;">Month Day Year</p> <p>Date of Birth _____ / _____ / _____</p> <p>Age _____</p> <p>SOCIAL SECURITY NUMBER (optional for non-applicants) _____</p>	<p>Wants Medical Assistance</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p> <p>Sex</p> <p><input type="checkbox"/> Male</p> <p><input type="checkbox"/> Female</p>	<p>Relationship to You</p> <p><input type="checkbox"/> Self</p> <p><input type="checkbox"/> Spouse</p> <p><input type="checkbox"/> Child</p> <p><input type="checkbox"/> Stepchild</p> <p><input type="checkbox"/> Other (specify): _____</p>	<p>Marital Status</p> <p><input type="checkbox"/> Single</p> <p><input type="checkbox"/> Married</p> <p><input type="checkbox"/> Separated</p> <p><input type="checkbox"/> Divorced</p> <p><input type="checkbox"/> Widowed</p>	<p>Citizenship (optional for non-applicants)</p> <p><input type="checkbox"/> U.S. or U.S. National</p> <p><input type="checkbox"/> CFA Individual</p> <p><input type="checkbox"/> Lawful Permanent Resident</p> <p>Entry Date: _____</p> <p><input type="checkbox"/> Other (specify): _____</p>	<p>Ethnicity (optional)</p> <p><input type="checkbox"/> Caucasian</p> <p><input type="checkbox"/> Chinese</p> <p><input type="checkbox"/> Filipino</p> <p><input type="checkbox"/> Hawaiian</p> <p><input type="checkbox"/> Japanese</p> <p><input type="checkbox"/> Other (specify): _____</p>
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E. Last Name _____ **Wants Medical Assistance**
First Name _____ Yes
Middle Initial _____ No
Month Day Year
Date of Birth ____ / ____ / ____ **Sex**
 Male Female
Age _____

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

Marital Status
 Single
 Married
 Separated
 Divorced
 Widowed

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

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

SOCIAL SECURITY NUMBER (optional for non-applicants) _____

F. Last Name _____ **Wants Medical Assistance**
First Name _____ Yes
Middle Initial _____ No
Month Day Year
Date of Birth ____ / ____ / ____ **Sex**
 Male Female
Age _____

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

Marital Status
 Single
 Married
 Separated
 Divorced
 Widowed

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

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

SOCIAL SECURITY NUMBER (optional for non-applicants) _____

G. Last Name _____ **Wants Medical Assistance**
First Name _____ Yes
Middle Initial _____ No
Month Day Year
Date of Birth ____ / ____ / ____ **Sex**
 Male Female
Age _____

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

Marital Status
 Single
 Married
 Separated
 Divorced
 Widowed

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

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

SOCIAL SECURITY NUMBER (optional for non-applicants) _____

H. Last Name _____ **Wants Medical Assistance**
First Name _____ Yes
Middle Initial _____ No
Month Day Year
Date of Birth ____ / ____ / ____ **Sex**
 Male Female
Age _____

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

Marital Status
 Single
 Married
 Separated
 Divorced
 Widowed

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

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

SOCIAL SECURITY NUMBER (optional for non-applicants) _____

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

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

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

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

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

YES NO

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

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

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

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

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

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

- D. Does anyone who is blind or disabled have unpaid medical bills for the past 3 months?** *(We may be able to help pay the bills.)*

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

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

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

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

I certify the information I have provided on this application is true to the best of my knowledge. If I intentionally make false statements on this application, I may be prosecuted under Hawaii Revised Statutes §710-1063. I give permission to the State of Hawaii to check my statements. I have read or had read to me the list of rights and responsibilities on page 9 that I may keep for my information.

Applicant's Signature _____ Date _____

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

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

Representative's Name (Print) _____ Signature _____ Relationship _____ Telephone Number _____ Date _____

[OFFICIAL USE ONLY: MQD EW NAME (Print) _____ SIGNATURE _____ APPLICATION REVIEW DATE _____]

Bilingual and Sign Interpreter Services

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

Common Questions and Answers

Pregnant Women

How long does it take for my application to be processed?

Med-QUEST will process your application within 5 business days if you answer all questions on the application.

What should I do after the baby is born?

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

How long will my medical assistance continue?

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

If I am not eligible for Med-QUEST's programs, can I apply for my baby?

Yes. If your baby is eligible, benefits begin on the date Med-QUEST receives the application. Also, if you want your birth expenses covered, Med-QUEST must

receive your application within 5 calendar days of the baby's delivery. It would be helpful to complete the application before you go to the hospital, take it with you, and ask the hospital staff to fax it to your local Med-QUEST office.

Children

How long does it take for my application to be processed?

Med-QUEST has up to 45 days from the date it gets your application to approve or deny it. However, if the person who needs medical assistance is blind or disabled, they have 60 days to review it.

How soon can my child get health care?

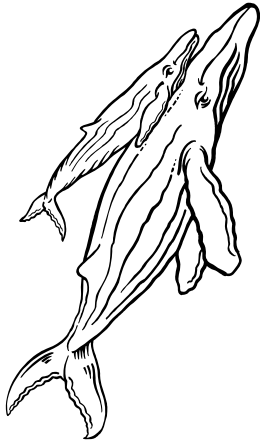
If the application is approved, benefits begin on the date Med-QUEST received the application.

If my child gets sick before the application is approved, what should I do?

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

Will enrolling in QUEST or Medicaid Fee-for-Service affect my immigration status?

No. It will not affect your child's or family's immigration status. Visit the Bureau of Citizenship and Immigration web site at <http://uscis.gov/graphics/publicaffairs/presinfo4.htm#publiccharge> or call their national customer service center at 1-800-375-5283 for details.



Important Resources

211

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

Child Abuse and Neglect

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

WIC

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

Head Start

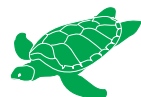
Child development programs that serve children from birth to age 5 years old and their families. www.ehawaii.gov.org/childcare

MothersCare

Links pregnant women to medical care, health insurance, maternity classes, teen pregnancy programs, and community resources. 535-7988 (Oahu), 1-877-535-7988 (Neighbor Islands), or www.MothersCareHawaii.org

Parent Line

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





Mikah The Myna Bird has friendly advice...

Regular health check-ups are no Myna matter!

EPSDT provides free **E**arly and **P**eriodic **S**creening, **D**iagnosis, and **T**reatment health services for individuals under 21 years old receiving medical assistance through Hawaii QUEST, QUEST-Net, and Medicaid Fee-For-Service programs.

EPSDT offers:

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

😊 Regular health check-ups can keep you healthy 😊

What is EPSDT?

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

Why should EPSDT concern me?

It is important that children and youth get regular checkups so their doctors find health problems before they become serious.

Who can use this program?

Individuals from birth through 20 years old with a Hawaii QUEST, QUEST-Net, or Medicaid Fee-for-Service card.

How can the person get EPSDT services?

Individuals in Hawaii QUEST or QUEST-Net get medical services through their health plans and dental services from dentists who treat patients covered by Medicaid. Individuals in the Medicaid Fee-For-Service program get medical and dental services from doctors and dentists who treat patients covered by Medicaid.

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

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

RIGHTS AND RESPONSIBILITIES

WHAT I HAVE THE RIGHT TO EXPECT FROM THE DEPARTMENT:

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

NO DISCRIMINATION: I will not be treated differently because of my race, color, age, sex, national origin, physical or mental disability, or religious or political beliefs. If I am not satisfied with the way I am treated, I should write to the Department of Human Services Personnel – Civil Rights Compliance Unit, P.O. Box 339, Honolulu, Hawaii 96809-0339 or the U.S. Department of Health and Human Services, Office of Civil Rights/Region IX, 50 United Nations Plaza, Room 322, San Francisco, California 94102, Attention: Regional Manager, as soon as possible. I may also call the US DHHS at 1-800-368-1019 (toll free) or 1-415-437-8311 (TDD).

FAIR AND FRIENDLY TREATMENT: The Department will make an eligibility determination based on facts within 45 days from the date the application is received by the Department or within 60 days for someone who is applying for medical assistance based on a disability. I will be given correct information and treated with dignity and courtesy at all times.

BILINGUAL, SIGN INTERPRETER, OR OTHER ACCOMMODATIONS: I can get help to access medical assistance with sign or foreign language interpreters, large print, taped materials or accessible parking, etc. at no charge.

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

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

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

WHAT THE DEPARTMENT HAS THE RIGHT TO EXPECT OF ME:

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

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

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

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

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

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

APPLYING FOR MEDICAL ASSISTANCE

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

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

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