

INSTRUCTIONS

DHS 1100 (Rev. 06/09)

MEDICAL ASSISTANCE APPLICATION FORM

PURPOSE:

The DHS 1100, Medical Assistance Application Form, shall be used as the basic document for initial application of the medical assistance program. This form shall also be used to add a person(s) to an existing case.

NOTE: The DHS 1100 shall also be used as the vehicle to request for medical assistance in conjunction with the DHS 1240, Application for Financial and Food Stamps for the initial application or reapplication for the financial, medical and food stamp combination programs.

GENERAL INSTRUCTIONS:

1. An individual shall complete the DHS 1100 whenever an application for the medical program is being completed. The DHS 1100 shall be completed and signed by a responsible household member. If the applicant is incapable of acting on his or her own behalf or is deceased, persons who may apply on behalf of the applicant include the applicant/recipient's guardian, conservator, or executor, a person who knows of the applicant's need to apply, a representative of a public agency, or other responsible and concerned persons.
2. The eligibility worker (EW) shall verify the information provided on the DHS 1100 and record the source of verification on the DHS 1100A, Eligibility Determination Form.

NOTE: If the applicant is unable to complete the entire application, he/she must provide his or her name and mailing address on page one, and signature on page six. EW shall contact the applicant to obtain the necessary information to determine eligibility.

Page 1

1. WHO YOU ARE AND WHERE YOU LIVE?

A responsible household member shall complete his/her name, best phone number to call, home address, mailing address, and what language he/she speaks best.

The applicant shall provide basic information on the household members applying for assistance.

2. CHECK 'YES' OR 'NO' IN THE FOLLOWING QUESTIONS:

- | | |
|---|--|
| A. Is anyone who wants medical assistance pregnant? | Complete Name of the pregnant household member, Due date, and Number of expected children. |
| B. Was the pregnancy confirmed by a home pregnancy test or health care provider? | Check "Yes" box to indicate if the pregnancy was confirmed by a home pregnancy test or health care provider. (Note: If the answer is No, verification is required) |
| C. Is anyone who wants medical assistance 18-20 years old and claimed as a tax dependent? | Complete Name of the household member. |
| D. Is anyone self employed? | Complete Name of the household member. |
| E. Is anyone who wants medical assistance in a medical institution or applying for long-term care placement, home and community-based services, DD/MR, or PACE? | Complete Name of the household member, nursing home name and placement date.
(Explanation of acronym is on p.8) |

- F. Is anyone who wants medical assistance age 0-18 years old and has an absent or deceased parent? Complete Name of the household member.
- G. Is anyone blind, disabled, or age 65 or older? Complete Name of the household member.

Page 2 & 3

- Name: Last name, First name and Middle initial.
 Date of birth: Month, Day and Year.
 Age: Self explanatory.
 Social Security Number: Self explanatory, optional for non-applicants.
 Wants Medical Assistance: Check "Yes" or "No" if the household member wants medical or not.
 Sex: Check "Male" or "Female".
 Relationship to You: Check "Self", "Spouse", "Child", "Stepchild", or "Other".
 Marital Status: Check "Single", "Married", "Separated", "Divorced", or "Widowed".
 Citizen: Check "U.S. or U.S. National", "CFA Individual" "Lawful Permanent Resident Entry Date", or "Other"
 (Optional for non-applicants)
 Ethnicity (optional): Check "Caucasian", "Chinese", "Filipino", "Hawaiian", "Japanese", or "Other"

Page 4

4. HOUSEHOLD INCOME INFORMATION:

- A. Check if no income: Explain how the household's daily needs are paid.
- B. Check "Yes" or "No" for the type of income: Complete the household member's name who has income , the monthly gross amount and attach document copies.
- Self-Employment Income
 - Social Security Benefits
 - Supplemental Security Income (SSI)
 - Pension/Retirement Income Write who pays you
 - Veteran's Benefits Write who pays you
 - Temporary Disability Insurance (TDI)
 - Workers Compensation
 - Unemployment Insurance Benefits (UIB)
 - Insurance Settlements Write who pays you
 - School Grants, Loans, and Scholarships Write type and dates:
 - Child Support
 - Alimony
 - Child's Income
 - Other Income Explain other incomes

5. CHILDCARE INFORMATION:

Check "Yes" or "No" if someone pays childcare in order to work. If "Yes", list the name of the person or agency paying childcare, amount of monthly childcare cost, name of the child receiving care, and name of childcare provider,

Page 5

6. HOUSEHOLD ASSET INFORMATION:

List all household assets as of the first day of this month. Attach documents to verify each asset listed.

- A. Check here if no assets or if the applicant is only requesting medical assistance for persons who are 0-18 years old or a pregnant woman. Then skip to question number 7.
- B. Check "Yes" or "No" for every type of asset: Complete the household member's name who owns the asset and the dollar value of the type of asset. Attach documents for every type of asset you check 'YES'.
Write all
Write all
- Checking accounts
 - Saving Accounts
 - Cash
 - Income Tax Refunds
 - Stocks and Bonds
 - Money Market Accounts, CDs, & Time Cert
 - IRA, Keogh, & Deferred Compensation
 - Home or Mobile Home
 - Other Houses, Land, and Buildings
 - Burial Plans (Original Purchase Price)
 - Burial Plots
 - Life Insurance (Surrender Cash Value)
 - Family or Individual Trust Funds
 - Business Equity (Self-Employed)
 - Boats and Trailers
 - Jewelry, Diamonds, Gold, Silver, Etc.
- Total Number
Total Number

7. NURSING HOME SERVICES:

- A. Does anyone who needs medical assistance for long-term care, home and community-based services, DD/MR, or PACE sold, traded, or given away money, property, other resources, or assets in the past 5 years? Check "Yes" or "No". If "Yes", list the Items Sold, Traded, etc, Transaction date, Reason for Sale, Transfer, etc., Actual Amount Owed, Actual Value, and Amount Received.
- B. Does anyone who needs nursing home assistance or the person's spouse have an annuity? Check "Yes" or "No". If "Yes", list Owner's Name, Annuity Company, Policy Number and Value.

Page 6

8. MISCELLANEOUS QUESTIONS

- A. Does anyone listed in Question 3 have private health, dental, vision or long-term Care insurance, Medicare, TRICARE, VA benefits, or prescription drug coverage? If "Yes" checked, list Person's Name, Insurance Name, Type, and Policy Number, Start Month/Year, and Premium Amount.
- B. Has an employer offered health insurance to anyone who is employed? If "Yes", list Person's Name, Insurance Name, Type, Policy Number, Start Month/Year, and Employer's Name.
- C. Did anyone lose employer-provided health insurance or COBRA in the past 45 days? If "Yes", list person's name and last day covered.
- D. Has anyone been hospitalized or gone to an emergency room in the past 5 days? If "Yes", complete Person's Name, Service Dates, and Provider (Doctor, Hospital, etc.)
- E. Does anyone who is blind, disabled, or 65 years old or older have unpaid medical bills for the past 3 months? If "Yes", complete Person's Name, Service Dates, and Provider (Doctor, Hospital, etc.)

F. Does anyone have medical problems or need medical treatment due to an accident or incident?

If "Yes", complete Person's Name, Accident/Incident Date, and Provider (Doctor, Hospital, etc.)

G. Does anyone need on-going medical treatment doctor visits, prescriptions, etc?

If "Yes", complete Person's Name, Expected Monthly cost, and Provider (Doctor, Hospital, etc.)

9. CERTIFICATION BY A RESPONSIBLE HOUSEHOLD MEMBER:

A responsible household member shall sign and date certifying that he/she has read and was informed of his/her rights and responsibilities listed on page 11 and certified that the information provided on this form is true to the best of his/her knowledge. He/she further permits the State of Hawaii to check on his/her statements.

10. CERTIFICATION BY PERSON ASSISTING THE APPLICANT IN COMPLETING THIS APPLICATION

Complete if applicable.
The authorized representative shall sign and date form certifying that he/she helped complete the form, understands the criminal penalties for providing false information and explains how the information on the application form was obtained. The authorized representative shall sign name, print name, state relationship to the applicant, and enter the date the form is signed.

11. CERTIFICATION BY ELIGIBILITY WORKER:

EW shall certify that he/she has reviewed the application by printing and signing his/her name and date the application was reviewed, under "Official Use Only" on page 6.

**Page 7
BILINGUAL AND SIGN INTERPRETER SERVICES**

**Page 8
GENERAL QUESTIONS AND ANSWERS**

**Page 9
QUESTIONS AND ANSWERS FOR CHILDREN AND PREGNANT WOMEN**

**Page 10
MIKAH THE MYNA BIRD**

**Page 11
RIGHTS AND RESPONSIBILITIES**

The eligibility worker shall ensure a copy of the Rights and Responsibilities listed on page 11 is provided to the applicant.

Expectations of the Department:

- ❖ Right to Confidentiality
- ❖ No Discrimination
- ❖ Fair and Friendly Treatment
- ❖ Bilingual, Sign Interpreter or Other Accommodations- available if you do not speak or write in English
- ❖ Right to Advance Notice and Administrative Appeal
- ❖ Pre-existing Conditions
- ❖ EPSDT

Expectations of the Applicant:

- ❖ Social security number;
- ❖ Citizenship
- ❖ Cooperation and Good Cause
- ❖ Third Party Liability
- ❖ Assets and Other Properties
(Annuities-If purchased after February 6, 2006, the State must be named as a remainder beneficiary.)
- ❖ Reporting Any Changes
- ❖ Verification of Information
- ❖ Penalty Warning

Page 12

APPLYING FOR MEDICAL ASSISTANCE

Completed application can be mailed, dropped off, or faxed to the appropriate Med-Quest Eligibility office listed here. Any questions regarding the application can be answered by the local eligibility office.