INSTRUCTIONS

DHS 1108 (Rev. 06/09)

MEDICAL ASSISTANCE APPLICATION FOR CHILDREN AND PREGNANT WOMEN ONLY FORM

PURPOSE:

The DHS 1108, Medical Assistance Application for Children and Pregnant Women Only Form, shall be used for the initial application of the medical assistance program by children and pregnant women. This form shall also be used to add a person(s) to an existing case.

GENERAL INSTRUCTIONS:

1. Children and pregnant women shall complete the DHS 1108 whenever an application for the medical program is being completed. The DHS 1108 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 applicants' 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 1108 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 telephone 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" FOR THE FOLLOWING QUESTIONS:

	Question	Instruction
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 tax dependent household member.
D.	Is anyone self employed?	Complete name of the self-employed household member.
E.	Is anyone blind or disabled?	Complete Name of the blind or disabled household member.

Page 2 & 3

Field	Instruction
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"

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: (Optional for non-applicants)	Check “U.S. or U.S. National”, “CFA Individual”, “Lawful Permanent Resident (list Entry Date)”, or “Other”
Ethnicity (optional):	Check “Caucasian”, ”Chinese”, “Filipino”, “Hawaiian”, “Japanese”, or “Other”

Page 4

4. HOUSEHOLD INCOME INFORMATION:

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

Page 5

5. MISCELLANEOUS QUESTIONS

A. Does anyone listed in Question 3 have private health, dental insurance, vision insurance, long-term care insurance, Medicare, TRICARE, VA benefits or prescription drug coverage?	If “Yes” is checked, complete 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” is checked, complete Person’s Name, Insurance Name, Type, Policy Number, Start Month/Year, and Employer’s Name.
C. Did anyone lose employer-provided health insurance or extended health care coverage (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” is checked, complete Person’s Name, Service Dates, and Provider (Doctor, Hospital, etc.).
E. Does anyone who is blind or disabled, have unpaid medical bills the past 3 months?	If “Yes” is checked, 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” is checked, complete Person’s Name, Accident or Incident Dates, and Provider (Doctor, Hospital, etc.).

6. CERTIFICATION BY A RESPONSIBLE HOUSEHOLD MEMBER:	A responsible household member shall sign and date certifying that the information provided on this form is true to the best of his/her knowledge and that if he/she intentionally makes false statements, he/she may be prosecuted under HRS §710-1063. He/she further permits the State of Hawaii to check on his/her statements and that he/she has read or been informed of his/her rights and responsibilities listed on page 9.
7. CERTIFICATION BY PERSON ASSISTING THE APPLICANT IN COMPLETING THE 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 this form is signed.
CERTIFICATION BY ELIGIBILITY WORKER:	MQD EW shall certify that he/she has reviewed the application by printing and signing his/her name under "Official Use Only" on page 5. Also, indicate the date EW review the application form
Page 6 **BILINGUAL AND SIGN INTERPRETER SERVICES**	Self Explanatory
Page 7 **COMMON QUESTIONS AND ANSWERS**	Self Explanatory
Page 8 **Mikah The Myna Bird**	Self Explanatory
Page 9 **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 a Fair Hearing ❖ Pre-existing Conditions ❖ EPSDT **Expectations of the Applicant:** ❖ Social security number; ❖ Citizenship ❖ Third Party Liability ❖ Reporting Any Changes ❖ Verification of Information ❖ Penalty Warning
Page 10 **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.