

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

**1. Please tell us who you are and where you live. Also write your name and information in number 3A.**

Last Name	First Name	Middle Initial	Daytime Telephone Number	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 in the boxes below. If you check YES, please complete.**

YES    NO

- A. Is anyone who wants medical assistance pregnant?** *(Unborn children may be counted in determining the pregnant woman's household size.)*  
Name \_\_\_\_\_ Due Date \_\_\_\_\_ Number of children expected \_\_\_\_\_
- B. Was the pregnancy confirmed by a home pregnancy test or health care provider (doctor, nurse midwife, nurse practitioner, or family nurse practitioner)?** *(If the answer is NO, we will request verification.)*
- C. Is anyone who wants medical assistance 18-20 years old and claimed as a tax dependent?** *(The tax dependent's parents or legal guardians' income is counted for the QUEST program.)*  
Name \_\_\_\_\_
- D. Is anyone self employed?** *(You may be eligible for certain self-employment deductions.)*  
Name \_\_\_\_\_
- E. Is anyone who wants medical assistance in a nursing home or applying for nursing home placement?** *(You may be asked to provide more information about assets that you owned.)*  
Name \_\_\_\_\_ Nursing Home Name \_\_\_\_\_ Placement Date \_\_\_\_\_
- F. Is anyone who wants medical assistance 0-18 years old and has an absent or deceased parent?** *(You may be asked to complete more forms.)*  
Name \_\_\_\_\_
- G. Is anyone blind, disabled, or 65 years old or older?** *(You may receive certain income deductions and help with unpaid medical bills.)*  
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. Attach another paper if there are more than 8 persons.**

- A social security number and citizenship information are not needed for a person who does not want medical assistance (non-applicant). However, we may need to ask for more information if a social security number is not provided.
- Ethnicity is optional for everyone.

<p><b>A. Last Name</b> _____</p> <p><b>First Name</b> _____</p> <p><b>Middle Initial</b> _____</p> <p style="text-align: center;">Month      Day      Year</p> <p><b>Date of Birth</b> _____ / _____ / _____</p> <p><b>Age</b> _____</p> <p><b>Social Security Number</b> (optional for non-applicants) _____</p>	<p><b>Wants Medical Assistance</b></p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p> <p><b>Sex</b></p> <p><input type="checkbox"/> Male</p> <p><input type="checkbox"/> Female</p>	<p><b>Relationship to You</b></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><b>Marital Status</b></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><b>Citizenship</b> (optional for non-applicants)</p> <p><input type="checkbox"/> U.S. or U.S. National</p> <p><input type="checkbox"/> Permanent Resident Alien or CFA Individual</p> <p>Entry Date: _____</p> <p><input type="checkbox"/> Other (specify): _____</p>	<p><b>Ethnicity</b> (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>
---	---	--	--	--	--

<p><b>B. Last Name</b> _____</p> <p><b>First Name</b> _____</p> <p><b>Middle Initial</b> _____</p> <p style="text-align: center;">Month      Day      Year</p> <p><b>Date of Birth</b> _____ / _____ / _____</p> <p><b>Age</b> _____</p> <p><b>Social Security Number</b> (optional for non-applicants) _____</p>	<p><b>Wants Medical Assistance</b></p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p> <p><b>Sex</b></p> <p><input type="checkbox"/> Male</p> <p><input type="checkbox"/> Female</p>	<p><b>Relationship to You</b></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><b>Marital Status</b></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><b>Citizenship</b> (optional for non-applicants)</p> <p><input type="checkbox"/> U.S. or U.S. National</p> <p><input type="checkbox"/> Permanent Resident Alien or CFA Individual</p> <p>Entry Date: _____</p> <p><input type="checkbox"/> Other (specify): _____</p>	<p><b>Ethnicity</b> (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>
---	---	--	--	--	--

<p><b>C. Last Name</b> _____</p> <p><b>First Name</b> _____</p> <p><b>Middle Initial</b> _____</p> <p style="text-align: center;">Month      Day      Year</p> <p><b>Date of Birth</b> _____ / _____ / _____</p> <p><b>Age</b> _____</p> <p><b>Social Security Number</b> (optional for non-applicants) _____</p>	<p><b>Wants Medical Assistance</b></p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p> <p><b>Sex</b></p> <p><input type="checkbox"/> Male</p> <p><input type="checkbox"/> Female</p>	<p><b>Relationship to You</b></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><b>Marital Status</b></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><b>Citizenship</b> (optional for non-applicants)</p> <p><input type="checkbox"/> U.S. or U.S. National</p> <p><input type="checkbox"/> Permanent Resident Alien or CFA Individual</p> <p>Entry Date: _____</p> <p><input type="checkbox"/> Other (specify): _____</p>	<p><b>Ethnicity</b> (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>
---	---	--	--	--	--

<p><b>D. Last Name</b> _____</p> <p><b>First Name</b> _____</p> <p><b>Middle Initial</b> _____</p> <p style="text-align: center;">Month      Day      Year</p> <p><b>Date of Birth</b> _____ / _____ / _____</p> <p><b>Age</b> _____</p> <p><b>Social Security Number</b> (optional for non-applicants) _____</p>	<p><b>Wants Medical Assistance</b></p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p> <p><b>Sex</b></p> <p><input type="checkbox"/> Male</p> <p><input type="checkbox"/> Female</p>	<p><b>Relationship to You</b></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><b>Marital Status</b></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><b>Citizenship</b> (optional for non-applicants)</p> <p><input type="checkbox"/> U.S. or U.S. National</p> <p><input type="checkbox"/> Permanent Resident Alien or CFA Individual</p> <p>Entry Date: _____</p> <p><input type="checkbox"/> Other (specify): _____</p>	<p><b>Ethnicity</b> (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>
---	---	--	--	--	--

**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  
 Permanent Resident Alien or CFA Individual  
 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  
 Permanent Resident Alien or CFA Individual  
 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  
 Permanent Resident Alien or CFA Individual  
 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  
 Permanent Resident Alien or CFA Individual  
 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. 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		
		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		\$
<input type="checkbox"/>	<input type="checkbox"/>	Veteran's Benefits		\$
<input type="checkbox"/>	<input type="checkbox"/>	Temporary Disability Insurance (TDI)		\$
<input type="checkbox"/>	<input type="checkbox"/>	Worker's Compensation		\$
<input type="checkbox"/>	<input type="checkbox"/>	Unemployment Insurance Benefits (UIB)		\$
<input type="checkbox"/>	<input type="checkbox"/>	Insurance Settlements		\$
<input type="checkbox"/>	<input type="checkbox"/>	School Grants, Loans, 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:		\$

**5.**  YES  NO **Does anyone pay for childcare? If you check YES, please complete. (You may be allowed these deductions.)**

Person Who Pays	Monthly Cost	Name of Child	Person Providing Care
	\$		
	\$		
	\$		

**6. Please list ALL household assets as of the first day of this month.**

A. Check here if you are only requesting medical assistance for persons who are 0-18 years old or a pregnant woman and go to number 7.

B. Check YES or NO for **every type** of asset listed. Write the owner's name and its value. Completing this information will help us process your application faster.

YES	NO	Assets	Owner's Name	Dollar Value
<input type="checkbox"/>	<input type="checkbox"/>	Checking Accounts		\$
<input type="checkbox"/>	<input type="checkbox"/>	Savings Accounts		\$
<input type="checkbox"/>	<input type="checkbox"/>	Cash		\$
<input type="checkbox"/>	<input type="checkbox"/>	Income Tax Refunds		\$
<input type="checkbox"/>	<input type="checkbox"/>	Stocks and Bonds		\$
<input type="checkbox"/>	<input type="checkbox"/>	Money Market Accounts, CDs, and Time Certificates		\$
<input type="checkbox"/>	<input type="checkbox"/>	IRA, Keogh, and Deferred Compensation		\$
<input type="checkbox"/>	<input type="checkbox"/>	Home or Mobile Home		\$
<input type="checkbox"/>	<input type="checkbox"/>	Other Houses, Land, and Buildings		\$
<input type="checkbox"/>	<input type="checkbox"/>	Burial Plans		\$
<input type="checkbox"/>	<input type="checkbox"/>	Burial Plots		\$
<input type="checkbox"/>	<input type="checkbox"/>	Life Insurance (Surrender Cash Value)		\$
<input type="checkbox"/>	<input type="checkbox"/>	Trust Funds		\$
<input type="checkbox"/>	<input type="checkbox"/>	Business Equity (Self-Employed)		\$
<input type="checkbox"/>	<input type="checkbox"/>	Boats and Trailers		\$
<input type="checkbox"/>	<input type="checkbox"/>	Jewelry, Diamonds, Gold, Silver, Etc.		\$
<input type="checkbox"/>	<input type="checkbox"/>	Other Personal Property:		\$

YES NO

7.   **Does your family need assistance for nursing home costs? If you check YES, please tell us if anyone has sold, traded, or given away money, property, or other resources/assets in the past 5 years.** (You may not get help with nursing home costs if you disposed of your assets for less than fair market value.)

Items Sold, Traded, etc.	Date	Reason for Sale, Transfer, etc.	Actual Owed	Actual Value	Amount Received
			\$	\$	\$
			\$	\$	\$
			\$	\$	\$

**8. Please check YES or NO in the boxes below. If you check YES, please complete.**

YES NO

- A. Does anyone have health or dental insurance or has an employed person been offered health insurance by the employer for herself or himself?** *(Private health or dental insurance can help pay for some of your medical or dental costs.)*

Person's Name	Insurance Name, Type, and Policy Number	Effective Month/Year	Employer's Name	Premium Amount

- B. Did anyone lose employer provided health insurance or extended health care coverage (COBRA) in the past 45 days?** *(This may be a reason to allow you to enroll in the QUEST program.)*

Person's Name	Last Day Covered

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

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

- D. Does anyone who is blind, disabled, or 65 years old or older have unpaid medical bills for the past 3 months?** *(We may be able to help you pay them.)*

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

- E. Does anyone have medical problems due to an accident?** *(The responsible party may help pay your medical costs.)*

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

- F. Does anyone require ongoing medical treatment—doctor visits, prescriptions, etc.?** *(We may be able to help you pay them.)*

Person's Name	Expected Monthly Cost	Provider (Doctor, Hospital, etc.)

**9. 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 7 that I may keep for my information.

Applicant's Signature \_\_\_\_\_ Date \_\_\_\_\_

**10. 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/her.

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

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

## 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 the running of 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 a fair hearing. 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 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 these checkups.

### WHAT THE DEPARTMENT HAS THE RIGHT TO EXPECT OF ME:

**SOCIAL SECURITY NUMBER:** Social Security Numbers (SSN) 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.

**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; children who are 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.

**COOPERATION AND GOOD CAUSE:** Help is available to me through the Child Support Enforcement Agency (CSEA) if I need to obtain medical support for my children. I do not have to cooperate with CSEA if it is not in the best interest of my children. Otherwise, I will help my children get medical support by helping CSEA identify the father(s) of my children. 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 will not be eligible for medical assistance unless I am pregnant.

**THIRD PARTY LIABILITY:** I will give to 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.

**ASSETS AND OTHER PROPERTIES:** I must give the Department information about any asset or property that is owned by my household unless I am applying for medical assistance for children or as a pregnant woman. If I get rid of any asset or property for less money than the fair market value, it may affect my eligibility for nursing facility level of care.

**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 Control 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
<b>Oahu Applications Section</b> 801 Dillingham Boulevard, 3rd Floor Honolulu, HI 96817-4582	<b>Oahu Applications Section</b> P. O. Box 3490 Honolulu, HI 96811-3490	<b>Phone 587-3521</b> <b>Fax 587-3543</b>
<b>Kapolei Unit</b> Kakuhihewa State Office Building 601 Kamokila Boulevard, Room 415 Kapolei, HI 96707-2021	<b>Kapolei Unit</b> 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.
<b>East Hawaii Section</b> 88 Kanoelehua Avenue, Room 107 Hilo, HI 96720-4670	<b>East Hawaii Section</b> 88 Kanoelehua Avenue, Room 107 Hilo, HI 96720-4670	<b>Phone 933-0339</b> <b>Fax 933-0344</b>
<b>West Hawaii Section</b> Lanihau Professional Center 75-5591 Palani Road, Suite 3004 Kailua-Kona, HI 96740-3633	<b>West Hawaii Section</b> Lanihau Professional Center 75-5591 Palani Road, Suite 3004 Kailua-Kona, HI 96740-3633	<b>Phone 327-4970</b> <b>Fax 327-4975</b>
<b>Lanai Unit</b> 730 Lanai Avenue Lanai City, HI 96763	<b>Lanai Unit</b> P. O. Box 737 Lanai City, HI 96763	<b>Phone 565-7102</b> <b>Fax 565-6460</b>
<b>Maui Section</b> 2145 Wells Street, Suite 103 Wailuku, HI 96793-2225	<b>Maui Section</b> 2145 Wells Street, Suite 103 Wailuku, HI 96793-2225	<b>Phone 243-5780</b> <b>Fax 243-5788</b>
<b>Molokai Unit</b> State Civic Center 65 Makaena Street, Room 110 Kaunakakai, HI 96748	<b>Molokai Unit</b> P. O. Box 1619 Kaunakakai, HI 96748-0169	<b>Phone 553-1758</b> <b>Fax 553-3833</b>
<b>Kauai Unit</b> 4473 Pahee Street, Suite A Lihue, HI 96766-2037	<b>Kauai Unit</b> 4473 Pahee Street, Suite A Lihue, HI 96766-2037	<b>Phone 241-3575</b> <b>Fax 241-3583</b>