

## MEDICAL ASSISTANCE RENEWAL FORM

### OFFICIAL USE ONLY

|  |   |                       |
|--|---|-----------------------|
| Date Received By the Department of Human Services: | Organization Assisting With Renewal Form: | Case Name:            |
|  |   | Case Number:          |
|  |   | Worker's Name:        |
|  |   | Section/Unit/EW Code: |

Please fill out the following information to renew participation for medical assistance. If you are not able to complete the entire form, please have a family member or friend help you; otherwise, complete only the name and address section on page 1 and signature section on page 4. The eligibility worker can help you with the form if you need it.

**Please Print** (Tell us who you are and where you live.)

|  |                          |                          |          |
|--|--------------------------|--------------------------|----------|
| Last Name, First Name, Middle Initial            | Daytime Telephone Number | Message Telephone Number |          |
| Home Address (Where you live)                    | City                     | State                    | Zip Code |
| Mailing Address (if different from home address) | City                     | State                    | Zip Code |

### Household Information

1. Please list:

- The household member who moved out of or into the home.
- The household member in the home who does not have medical assistance, but now wants it.

Note that if you are married and your spouse moves in, that spouse must be included even if he/she does not want medical assistance. Also, if a child under age 19 is receiving or now wants medical assistance and the child is living with his/her parents or the child's parent moves in, the parent must be included even if the parent does not want medical assistance. If more space is needed, please attach a separate sheet.

| Complete only for new household members or for persons who now want medical. |                     |                |               |                       |                         |                |         |                      |                    |                  |                |
|--|---------------------|----------------|---------------|-----------------------|-------------------------|----------------|---------|----------------------|--------------------|------------------|----------------|
| Last Name, First Name, Middle Initial  | Relationship to you | Date Moved Out | Date Moved In | Wants Medical? Yes/No | Social Security Number* | Date of Birth* | Sex M/F | Ethnicity (optional) | US Citizen* Yes/No | Disabled* Yes/No | Marital Status |
|  |                     |                |               |                       |                         |                |         |                      |                    |                  |                |
|  |                     |                |               |                       |                         |                |         |                      |                    |                  |                |
|  |                     |                |               |                       |                         |                |         |                      |                    |                  |                |
|  |                     |                |               |                       |                         |                |         |                      |                    |                  |                |
|  |                     |                |               |                       |                         |                |         |                      |                    |                  |                |
|  |                     |                |               |                       |                         |                |         |                      |                    |                  |                |

\*Required for those who want Medical Assistance.

## Household Information (continued)

2. Yes  No  Is anyone who is receiving or wants medical assistance pregnant? (An unborn child may be counted in determining a pregnant woman's household size.)

If YES, please provide proof from your health care provider and give us the following information below.

| Name of Pregnant Woman | When is the delivery date? | How many babies are expected? |
|------------------------|----------------------------|-------------------------------|
|                        |                            |                               |

## Income Information

3. Yes  No  Does anyone in your household receive **EARNED INCOME** (such as wages, tips, self-employment, etc.) or **UNEARNED INCOME** (such as Social Security, SSI, unemployment insurance, pension/retirement, child/alimony support, etc.)?

If YES, please complete below and provide verification. If more space is needed, please attach a separate sheet.

| Name of Person Receiving Income | Source of Income<br>Employer, agency, or self-employed | How often income received?<br>Weekly, 2 times a month, every 2 weeks, monthly | Monthly Gross Amount<br>Before taxes/deductions |
|---------------------------------|--|---|---|
|                                 |  |   | \$  |
|                                 |  |   | \$  |
|                                 |  |   | \$  |
|                                 |  |   | \$  |
|                                 |  |   | \$  |
|                                 |  |   | \$  |
|                                 |  |   | \$  |

4. If you do not receive any monthly income, please tell us how your family pays for food, rent, clothing, and other living expenses:

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## Childcare Information

5. Yes  No  Does anyone pay for childcare in order to work? (You may be allowed these deductions.)

If YES, please complete below and provide verification. If more space is needed, please attach a separate sheet.

| Name of person or agency paying childcare expense? | Name of child who is being cared for? | Who provides the care?<br>Name of childcare provider | Amount of Monthly Childcare Payment |
|--|---------------------------------------|--|-------------------------------------|
|  |                                       |  | \$                                  |
|  |                                       |  | \$                                  |

**Asset Information** If medical assistance is requested for only children or pregnant women, skip this section and go to question number 7. However, if you are receiving QUEST-Net or requesting medical assistance for adults who are not pregnant, you must complete this section.

6. Yes  No  Does anyone in your household own any assets including any jointly owned bank accounts, real property, personal property, stocks, bonds, funeral plan, burial plot, life insurance plan, etc.?

If YES, please complete below and submit verification. If more space is needed, please attach a separate sheet.

| Name of Person with Asset | Type of Asset | Cash Value |
|---------------------------|---------------|------------|
|                           |               | \$         |
|                           |               | \$         |
|                           |               | \$         |
|                           |               | \$         |
|                           |               | \$         |
|                           |               | \$         |
|                           |               | \$         |

**Insurance Information**

7. Yes  No  Does anyone have health insurance or dental insurance (other than QUEST or Medicaid Fee-For-Service)?  
If YES, please complete below and provide a copy of your health insurance and/or dental insurance card(s). If more space is needed, please attach a separate sheet.

| Name of Person Covered | Insurance Company Name, Type of Coverage, Address, and Telephone Number | Effective Date | Policy or Claim Number | Employer's Name | Monthly Premium Amount |
|------------------------|---|----------------|------------------------|-----------------|------------------------|
|                        |   |                |                        |                 | \$                     |
|                        |   |                |                        |                 | \$                     |
|                        |   |                |                        |                 | \$                     |

8. Yes  No  Does anyone have medical problems due to an accident or injury, including worker's compensation? (The responsible party may help pay your medical costs.)

If YES, please complete below.

| Name of Injured Person | Type of Injury | Name of Insurance Company | Date Injured |
|------------------------|----------------|---------------------------|--------------|
|                        |                |                           |              |
|                        |                |                           |              |

**Nursing Home Services** Complete this section if a household member is receiving or now needs nursing home services. If you gave us the information before, skip this section.

9. Yes  No  Has anyone sold, traded, or given away property, or other resources/assets, including money, within the past 36 months, or made any transfers into a trust within the past 60 months? (You may not get help with nursing home costs if you disposed of your assets for less than fair market value.)

If YES, please complete below. If more space is needed, please attach a separate sheet.

| Name of Person Who Sold, Transferred, etc., Asset | Type of Asset Sold, Transferred, etc. | Reason for Sale, Transfer, etc. | Date of Transfer | Value | Amount Received |
|---|---------------------------------------|---------------------------------|------------------|-------|-----------------|
|   |                                       |                                 |                  | \$    | \$              |
|   |                                       |                                 |                  | \$    | \$              |
|   |                                       |                                 |                  | \$    | \$              |

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**CERTIFICATION:** 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 form is true to the best of my knowledge. 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 5 that I may keep for my information.

\_\_\_\_\_ Date \_\_\_\_\_

Signature

**CERTIFICATION BY PERSON ASSISTING IN COMPLETING THE RENEWAL FORM:** I helped the recipient complete this form or I am helping 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 recipient or  are what I personally know about him/her.

\_\_\_\_\_

Representative's Signature      Representative's Printed Name      Relationship      Date      Telephone Number

**OFFICIAL USE ONLY:**

\_\_\_\_\_

Eligibility Worker's Name (Print)      Eligibility Worker's Signature      Date

## RIGHTS AND RESPONSIBILITIES

(Please tear off and keep.)

### **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. You 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, if requested ahead of time.

**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 or 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. I may also receive help with scheduling appointments and transportation for these checkups if they are medically necessary.

### **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:** I swear under oath that those applying for assistance in my household are U.S. citizens, U.S. nationals, lawful resident aliens, or citizens of the Federated States of Micronesia, the Marshall Islands, or Palau for which I will provide proof of their lawful immigration status. I do not have to provide my citizenship or lawful immigration status if I am not applying for medical assistance or if I am a non-lawful alien 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.