

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? <i>(We will get you a FREE interpreter—see page 7.)</i>	

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

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

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B. Check YES or NO for **every type** of income listed. If YES, please write information in the boxes and **attach document copies**. 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 <b>Whole Month</b>
		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 (write type and dates: _____ )		\$
<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 insurance, dental insurance, vision insurance, long-term care 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. Did anyone lose employer-provided health insurance or extended health care coverage (COBRA) in the past 45 days?

Person's Name	Last Day Covered

- D. Does anyone have unpaid medical bills in the past 30 days? (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"/>	<b>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。</b>	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"/>	<b>Med-QUEST ຈະຈັດຫາ ນາຍພາສາ ທີ່ເວົ້າໄດ້ສອງພາສາ ຫລື ນາຍພາສາກຶກ ໃຫ້ຝຣີ. ແມ່ນແລ້ວ, ຂ້າພະເຈົ້າ ຕ້ອງການ ນາຍພາສາລາວ.</b>	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 30 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 90 days to review it.

### **How soon can my child get health care?**

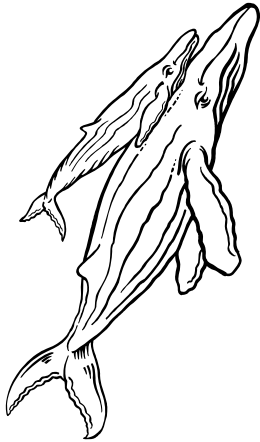
If the application is approved, benefits begin on the date Med-QUEST received the application.

### **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/](http://www.coveringkids.com/library/). After the doctor completes the form, bring it to Med-QUEST and they will review your application.

### **Will enrolling in a health plan or Fee-for-Service affect my immigration status?**

No. It will not affect your child's or family's immigration status. Call the national U.S. Citizenship and Immigration Services 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**

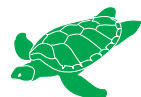
Child development programs that serve children from birth to age 5 years old and their families. [www.hawaii.gov/dhs/self-sufficiency/childcare/headstart/](http://www.hawaii.gov/dhs/self-sufficiency/childcare/headstart/)

### **MothersCare Information Line**

Operated by Healthy Mothers Healthy Babies Coalition of Hawaii. Links pregnant women to health and community resources. 951-6660 (Oahu), 1-888-951-6661 (Neighbor Islands), or [www.hmhb-hawaii.org](http://www.hmhb-hawaii.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 Med-QUEST's 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 receiving medical assistance through Med-QUEST's programs.

### How can the person get EPSDT services?

Individuals receiving medical assistance get EPSDT services through participating health care providers.

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 as soon as possible to the Department of Human Services Personnel, Civil Rights Compliance Unit, P. O. Box 339, Honolulu, HI 96809-0339 or the U. S. Department of Health and Human Services, Office of Civil Rights/Region IX, 90 7th Street, Suite 4-100, San Francisco, CA 94103-6705, Attention: Regional Manager. I may also call the US DHHS at 1-800-368-1019 (toll free) or 1-415-437-8311 (TDD). I can get a Discrimination Complaint Form, Consent/Release Form, and joint Nondiscrimination Notices in multiple languages at <http://hawaii.gov/dhs> in the Civil Rights Corner.

**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 90 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:** All Department oral and written communication to me will be in English. If I do not understand what I hear or read, I will contact the Department right away. I can get free help to access medical assistance with sign or foreign language interpreters, large print, taped materials, or accessible parking, etc.

**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.

<b>OFFICE ADDRESSES</b>	<b>MAILING ADDRESSES</b>	<b>TELEPHONE AND FACSIMILE NUMBERS</b>
<b>Oahu Section</b> 801 Dillingham Boulevard, 3rd Floor Honolulu, HI 96817-4582	<b>Oahu Section</b> P. O. Box 3490 Honolulu, HI 96811-3490	<b>Phone</b> 587-3521 or 587-3540 <b>Fax</b> 587-3543
<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	<b>Phone</b> 692-7364 <b>Fax</b> 692-7379
<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</b> 933-0339 <b>Fax</b> 933-0344
<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</b> 327-4970 <b>Fax</b> 327-4975
<b>Lanai Unit</b> 730 Lanai Avenue Lanai City, HI 96763	<b>Lanai Unit</b> P. O. Box 737 Lanai City, HI 96763-0737	<b>Phone</b> 565-7102 <b>Fax</b> 565-6460
<b>Maui Section</b> Millyard Plaza 210 Imi Kala Street, Suite 101 Wailuku, HI 96793-1274	<b>Maui Section</b> Millyard Plaza 210 Imi Kala Street, Suite 101 Wailuku, HI 96793-1274	<b>Phone</b> 243-5780 <b>Fax</b> 243-5788
<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 96748-1619	<b>Phone</b> 553-1758 <b>Fax</b> 553-3833
<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</b> 241-3575 <b>Fax</b> 241-3583

# IMPORTANT—Please Read and Attach Documents to Your Application!

## MEDICAL ASSISTANCE APPLICATION

### Income and Asset Information

Med-QUEST can process your application faster if you attach copies of your income documents such as a pay stub, Social Security award letter, retirement income statement, or other income proof. Also, if you write assets, you must attach copies.

### Request for U. S. Citizenship, Alien Status, and Photo Identification Documents

Please attach one copy of a citizenship or alien status document and one copy of photo identification for each person in your household who wants medical assistance.

If you need help completing the Med-QUEST application, please call 211 (free call from all islands) and ask for an outreach worker near your home. Also, the address and phone number for your local Med-QUEST office are on the last page of the application.

### Examples of Documents You Can Attach to Your Application

#### PHOTO IDENTIFICATION

Please attach a **copy** of ONE ITEM ONLY for each person who wants medical assistance:

- Passport
- State Identification Card
- Driver License or Permit
- School Identification
- Bus Pass
- Certificate of Naturalization or U.S. Citizenship
- Government Issued Card with Same Information as Driver License
- Draft Record
- U.S. Military or Military Dependent Card
- U.S. Coast Guard Merchant Mariner Card
- Certificate of Indian Blood or U.S. American Indian/Alaskan Native Tribal Document
- Permanent Resident Card (I-551)
- Other Official Photo Identification
- Affidavit (Children Under 16 Years Old Only)

#### U. S. CITIZENSHIP

Please attach a **copy** of ONE ITEM ONLY for each U.S. citizen who wants medical assistance:

- U.S. Passport
- Current Hawaii State Identification Card (front and back)
- Certified U.S. Birth Certificate
- Certificate of Naturalization (N-550 or N-570)
- Certificate of U.S. Citizenship (N-560 or N-561)
- Certificate or Report of Birth Abroad (DS-1350, FS-240, or FS-545)
- Northern Mariana Identification Card (I-873)
- American Indian KIC Card (I-872)
- U.S. Military Record (DD-214)
- U.S. Final Adoption Decree
- U.S. Civil Service Employment Before June 1, 1976
- U.S. Identification Card (I-179 or I-197)
- Verification with Department of Homeland Security's Systematic Alien Verification for Entitlements (SAVE) Database for Naturalized Citizens

#### ALIEN STATUS

Please attach a **copy** of ONE ITEM ONLY for each alien who wants medical assistance:

- Permanent Resident Card (I-551)
- Arrival/Departure Record (I-94)
- Recent Arrivals Only: Foreign Passport or I-94 with I-551 Stamp
- Employment Authorization Card (I-688B)
- Refugee Travel Document (I-571)
- U.S. Veteran Discharge Papers (DD-214)
- Active Duty Orders

### Lost U.S. Birth Certificates

If someone who needs medical assistance must get a new birth certificate, attach a copy of the birth certificate paper application or electronic confirmation and money order. The Med-QUEST eligibility worker will wait 45 days from the date Med-QUEST received the application to determine eligibility. When the birth certificate arrives in the mail, immediately send a **copy** to Med-QUEST or the person will be denied.

## Statement of Parent or Guardian for Children Under 16 Years Old

Identity Affidavit for Medicaid Programs (Deficit Reduction Act of 2005)

**This form meets the photo identity requirement for children under 16 years old.** If the children are not living with a parent, the guardian may complete it. Please print clearly. If there are more than ten children in the household, attach another affidavit form.

I, \_\_\_\_\_, am the parent or guardian of the children listed below.  
(Print Name of Parent or Guardian)

<b>Child's Legal Name</b> (First Name and Last Name)	<b>Birth Date</b> (Month, Day, and Year)	<b>Where Child Was Born</b> (City and Country)	<b>OFFICIAL USE ONLY</b>
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

I certify under penalty of perjury that the information I have provided in this affidavit is true to the best of my knowledge.

\_\_\_\_\_  
Signature of Parent or Guardian

\_\_\_\_\_  
Date