State of Hawaii
Department of Human Services

Med-QUEST Division
Application Date: _____
Date Sent: _____
Due Date: _____

Supplemental Form for Individuals Applying for Coverage On a Basis Other Than MAGI and/or for Their Requesting Long-Term Care Services
(Supplement to Form DHS 1100)

The information on this supplemental form provides additional information to form DHS 1100, "Application for Health Coverage & Help Paying Costs", necessary to process an application for individuals who may be eligible for coverage on a basis other than modified adjusted gross income (MAGI) and/or for requesting long-term care (LTC) services.

Name: _____

Address: _____

_____

If more space is needed for your responses, please use a separate sheet of paper and attach it to this supplemental form.

A. Tell us who needs coverage on a basis other than MAGI or LTC services and the setting.

1. First name, Middle initial, Last name, & Suffix	2. Date of Birth (mm/dd/yyyy) / /
3. Have you been certified as blind or disabled (i.e., receiving Supplemental Security Income (SSI) or Social Security blind/disabled benefits)? ☐ No If no, you may be required to complete additional forms. ☐ Yes	
4. Where do you want to have LTC services provided to you?	☐ At Home
☐ Nursing Facility Name: _____	☐ Date Admitted: _____
☐ Comm. Care Foster Family Home Name: _____	☐ Date Admitted: _____
5. Marital Status: ☐ Single ☐ Divorced ☐ Widow(er) ☐ Married	

B. Tell us who your spouse is that you want to provide financial support to.

1. Spouse's First name, Middle initial, Last name, & Suffix		
2. Date of Birth (mm/dd/yyyy) / /	3. Social Security Number _ _	4. Amount of Monthly Financial Support

C. Tell us who your dependent(s) is that you want to provide financial support to.

1. **Dependent #1:** First name, Middle initial, Last name, & Suffix		2. Date of birth (mm/dd/yyyy)
3. Gender ☐ Male ☐ Female	4. Social Security Number – –	5. Amount of Monthly Financial Support
6. **Dependent #2:** First name, Middle initial, Last name, & Suffix		7. Date of birth (mm/dd/yyyy)
8. Gender ☐ Male ☐ Female	9. Social Security Number – –	10.Amount of Monthly Financial Support

D. Tell us more about yourself and/or your spouse.

1. Do you and/or your spouse own a home property that you currently reside in? (You may need to complete additional forms.)
   ☐ No
   ☐ Yes If yes, please provide the following information.

OWNER'S NAME	PROPERTY ADDRESS	EQUITY VALUE
		$

2. Do you and/or your spouse own other properties other than your home property?

☐ No

☐ Yes If yes, please provide the following information.

OWNER'S NAME	PROPERTY ADDRESS	MARKET VALUE
		$
		$

3. Do you and/or your spouse own any assets? Check YES or NO for every type of asset listed below. If your assets are not on this list, check YES for Other Assets.

☐ No

☐ Yes If yes, please provide the following information as of the first day of this month.

YES	NO	ASSETS	OWNER'S NAME	BANK OR COMPANY NAME	EQUITY VALUE
☐	☐	Checking Accounts (List all)			$
☐	☐	Savings Accounts (List all)			$
☐	☐	Cash			$
☐	☐	Income Tax Refunds			$
☐	☐	Stocks and Bonds			$
☐	☐	Money Market Accounts, CDs, and Time Certificates			$
☐	☐	IRA, Keogh, and Deferred Compensation			$
☐	☐	Burial Plans: Total No. _____			$
☐	☐	Burial Plots: Total No. _____			$
☐	☐	Life Insurance (Surrender Cash Value)			$
☐	☐	Family or Individual Trust Funds			$
☐	☐	Business Equity (Self-Employed)			$
☐	☐	Boats and Trailers			$
☐	☐	Jewelry, Diamonds, Gold, Silver, Etc.			$
☐	☐	Other Assets			$

4. Did you and/or your spouse sell, trade, give away money, property, or other assets in the past 60 months? Or did you and/or your spouse make transfers into a trust within the past 60 months?

☐ No

☐ Yes If yes, please provide the following information.

ITEMS SOLD, TRADED, ETC.	TRANSACTION DATE	REASON FOR SALE, TRANSFER, ETC.	ACTUAL VALUE OF ITEMS	AMOUNT RECEIVED
			$	$
			$	$

5. Do you and/or your spouse own any annuities? (You may be asked to complete additional forms.)

☐ No

☐ Yes If yes, please provide the following information.

OWNER'S NAME	ISSUANCE DATE	NAME AND ADDRESS OF ANNUITY COMPANY

6. Do you and/or your spouse have a promissory note, loan, or mortgage?

☐ No

☐ Yes If yes, please provide the following information.

PROMISSORY NOTE, LOAN OR MORTGAGE	OWNER'S NAME	TRANSACTION DATE	ORIGINAL AMOUNT	BALANCE OWED
Promissory Note			$	$
Loan			$	$
Mortgage			$	$

7. Did you and/or your spouse purchase life estate interest in a property of another?

☐ No

☐ Yes If yes, please provide the following information.

OWNER'S NAME	TRANSACTION DATE	ADDRESS OF PROPERTY WITH LIFE ESTATE INTEREST	AMOUNT PAID
			$
			$

8. Did you and/or your spouse pay an entrance fee to enter a Continuing Care Retirement Community (CCRC) or Life Care Community (LCC)?

☐ No

☐ Yes If yes, please provide the following information.

OWNER'S NAME	TRANSACTION DATE	NAME AND ADDRESS OF CCRC/LCC	AMOUNT PAID
			$
			$

E. Tell us if you have health coverage.

1. Do you and/or your spouse have dental insurance, vision insurance, Medicare, TRICARE, VA benefits, other health insurance or prescription drug coverage?
(The other health insurance may help pay for the cost of your health coverage.)

☐ No

☐ Yes If yes, please provide the following information.

PERSON COVERED	NAME OF INSURANCE COMPANY	TYPE OF COVERAGE	POLICY NUMBER	EFFECTIVE DATE (mm/dd/yy)	MONTHLY PREMIUM AMOUNT
					$
					$
					$

2. Do you and/or your spouse need help with any unpaid medical bills in the past 3 months? (We may be able to help pay your medical bills.)

☐ No

☐ Yes If yes, please provide the following information.

PERSON WITH BILL	NAME OF PROVIDER (Doctor, Clinic, Hospital, etc.)	SERVICE DATES

F. Read and sign this supplemental form.

- I'm signing this supplemental form under penalty of perjury, which means, I've provided true answers to all the questions on this form to the best of my knowledge. I know that I may be subject to penalties under State or Federal law if I intentionally provide false or untrue information.

- I know that I must tell the Department of Human Services or the Hawaii Health Connector if anything changes (and is different than) from what I wrote on my application or this supplemental form. I can visit **www.mybenefits.hawaii.gov** or call toll free **1-877-628-5076** to report any changes. I understand that a change in my information could affect my eligibility.

- I know that under Federal law, discrimination isn't permitted on the basis of race, color, national origin, gender, age, sexual orientation, gender identity, or disability. I can file a complaint of discrimination by visiting **www.hhs.gov/ocr/office/file**.

- I confirm that I'm not incarcerated (detained or jailed).

We need this information to check your eligibility for help paying for health coverage if you choose to apply. We'll check your answers using information in our electronic databases and databases from the Internal Revenue Service (IRS), Social Security Administration, the Department of Homeland Security, and/or a consumer reporting agency. If the information doesn't match, we may ask you to send us proof.

If I'm Eligible for Medicaid

If I enroll in Medicaid, I'm giving the Medicaid agency my rights to pursue and get any money from other health insurance, legal settlements, or other third parties.

My Right to Appeal

If I think the Department of Human Services or the Hawaii Health Connector has made a mistake, I can appeal its decision. To appeal means to tell someone at the Department of Human Services or the Hawaii Health Connector that I think the action is wrong, and to ask for a fair review of the action. I know that I can find out how to appeal by contacting someone at **1-877-628-5076**. I know that I can be represented in the process by someone other than myself. My eligibility and other important information will be explained to me.

Sign this supplemental form. The person who filled out **section A** should sign this supplemental form. If you're an authorized representative, you may sign here as long as the **Appendix Section** is completed on the next page.

Signature	Date (mm/dd/yyyy)

PLEASE RETURN THIS FORM TO THE MED-QUEST ELIGIBILITY OFFICE CHECKED ON THE NEXT PAGE BY: _____.

MED-QUEST ELIGIBILITY OFFICES	
☐ MQD/EB-OAHU SECTION P. O. Box 3490 Honolulu, HI 96811-3490	☐ MQD/EB-KAPOLEI UNIT P. O. Box 29920 Honolulu, HI 96820-2320
☐ MQD/EB-EAST HAWAII SECTION 88 Kanoelehua Avenue Hilo, HI 96720-4670	☐ MQD/EB-KAUAI SECTION 4473 Pahee Street, Suite A Lihue, HI 96766-2037
☐ MQD/EB-WEST HAWAII SECTION Lanihau Professional Center 75-5591 Palani Road, Suite 3004 Kailua-Kona, HI 96740-3633	☐ MQD/EB-MAUI SECTION Millyard Plaza 210 Imi Kala Street, Suite 101 Wailuku, HI 96793-1274
☐ MQD/EB-LANAI UNIT P. O. Box 631374 Lanai City, HI 96763-0737	☐ MQD/EB-MOLOKAI UNIT P. O. Box 1619 Kaunakakai, HI 96748-1619

APPENDIX Assistance with completing this supplemental form:

- **You can choose an authorized representative.**
- **You can give a trusted person permission to talk about this supplemental form with us, see your information, and act for you on matters related to this supplemental form, including getting information about the status of your application request and signing this supplemental form on your behalf. This person is called an "authorized representative." If you ever need to change your authorized representative, call toll free, 1-877-628-5076. If you're a legally appointed representative for someone on this supplemental form, submit proof with this form.**

1. Name of authorized representative (First name, Middle name, Last name, & Suffix)		
2. Address		3. Apartment or suite number
4. City	5. State	6. ZIP Code
7. Phone No.		
8. Organization Name		9. ID No. (if applicable)
By signing this form, you will allow this person to sign this supplemental form, get official information about the status of your application, and act for you on all future matters with the Department.		
10.Your signature		11.Date (mm/dd/yyyy)

For certified application counselors, navigators, agents, and brokers only:
Complete this section if you're a certified application counselor, navigator, agent, or broker filling out this supplemental form for somebody else.

1. Application start date (mm/dd/yyyy)	
2. First name, Middle name, Last name, & Suffix	
3. Organization Name	4. ID No. (if applicable)