STATE OF HAWAII
DEPARTMENT OF HUMAN SERVICES

NOTICE TO APPLICANTS:

In order to complete your application for social services, you must submit all of the following information within thirty (30) days of the date your Application for Social Services form is received. To be considered complete, the following information must be provided:

* **You or your representative must sign and date the form.**

* **Your residence and mailing address must be complete**

* **List the name of the applicant (person or persons needing services.) You must include the names, birth dates, Social Security numbers, and whether anyone receives AFDC, Medicaid, or SSI benefits.**

* **IF YOU DO NOT RECEIVE MEDICAL ASSISTANCE FROM THE STATE OR SUPPLEMENTAL INCOME (SSI) BENEFITS, YOU NEED TO APPLY AND BE ELIGIBLE FOR THESE BENEFITS TO QUALIFY FOR CERTAIN SOCIAL SERVICE PROGRAMS, (I.E. CHORE SERVICES, ADULT DAY CARE SERVICES.)**

* **If you are in need of Chore Services for Adults, Foster Care Services for Adults or Day Care Serviced for Adults, you must submit a statement from a psychologist or physician licensed to practice in Hawaii which gives your diagnosis, prognosis, and the specific reason(s) you cannot manage without the service. A general statement of disability without showing its relationship to the services applied is not sufficient. A physical examination report is enclosed for your physician to complete.**

The Department had thirty (30) days from the date the Application for Social Services is received to determine whether or not you are eligible, therefore, it is essential that you submit all the noted information in order that we can determine if you are eligible or not.

IF YOU NEED AN INTERPRETER . . .

We provide interpreter services on request to conduct your business with this office.
If you need an interpreter in a particular language, point to that language below:


မြန်မာဘာသာနှင့်စကားပြန်လိုလျှင် ဤနေရာကိုလက်ညှိုးထိုးပြပါ။ Burmese


ចង្អុលចំនុះបើអ្នកត្រូវការអ្នកបកប្រែភាសានេះ Cambodian


E punto guene unnesesita intepete ni esta na lenguahe. Chamorro


Itini ikei ika pun ke osupwangen emon chon chiaku non kapasen ei neni ika fonu. Chuukese


Inā pono he mahele ʻōlelo Hawaiʻi iā ʻoe, e kuhikuhi mai iā ʻaneʻi nei. Hawaiian


Itudom ditoy no masapol mo ti interpreter ti sarita nga Ilocano. Ilocano


お話しになる言語を指して下さい。 Japanese


여러분이 이언어를 이해하시고 사용하시면
이곳을 가르키십시요
저희가 통역을 제공하겠읍니다 Korean


Kom fin nikin, kom enenu in oasr met leng kahs lom. Kosraen


ຖ້າທ່ານເວົ້າແລະເຂົ້າໃຈພາສານີ້, ໃຫ້ຊີ້ໃສ່ທີ່ນີ້. ນາຍພາສາຈະຊ່ວຍທ່ານ Lao


如果您明白此種語言，請指向本文。我們會提供該種語言翻譯員。 Mandarin or Cantonese


Jitōñe ñe elōñ am ñoñ rikook kajin. Marshallese


Idih wasabt ma ke anahne soun kawehwe ni lokaia wet. Pohnpeian


Afai e te mana'omia le faaliliu upu ile gagana Samoa faailoa mai faamolemole. Samoan


Apunte aqui si necesita un traductor en Español. Spanish


Ituro dito kung nanganga-ilangan ka ng tagapagsalin sa ganitong wika. Tagalog


กรุณาชี้ตรงนี้ถ้าต้องการผู้ชวยแปลภาษา Thai


Tuhu ki he tohi ni Kapau'oku Fie. ma'u ha Tokoni ke Fakamatala atu ʻae ʻuhinga ʻoe ton. Tongan


Chi vao dây nêu ban cân môt thông dich viên cho ngôn ngũ Vietnam. Vietnamese


Itudlo diri kung nanginahanglan ka ug taghubad niining pinulongan. Visayan (Cebuano)


Mu guchum ngarag ni faamra gabadag ninge thilyeg bee e thin rom. Yapese

Interpretation services may be provided at no charge in accordance with Chapter 371-33, Hawaii Revised Statutes.

For more Information about Hawaii's Language Access Law – Chapter 371, HRS (Part II), please visit www.hawaii.gov/labor/ola or call the Office of Language Access at (808) 586-8730.

State of Hawai'i

State of Hawaii
DEPARTMENT OF HUMAN SERVICES
Social Services Division
Adult & Community Care Services Branch

MEDICAL STATEMENT

PLEASE MAIL COMPLETED REPORT TO:

A D U L T I N T A K E U N I T
ADULT & COMMUNITY CARE SERVICES
OAHU SECTION
Department of Human Services
420 Waiakamilo Road, Suite 202
Honolulu, Hawaii 96817-4941

Consent to Release Information:

PRINT Last Name _____ First Name _____ Initial _____ Birth date ___/___/___

Address _____ City _____ Zip Code _____ ☐ M ☐ F

I hereby authorize the evaluating physician, physician assistant, advanced practice registered nurse, or medical facility to release to the Department of Human Services and its designees any information related to my past and present medical care, including substance abuse history and any information related to my HIV/AIDS status. I understand this information shall be used for the sole and limited purpose of determining eligibility for services provided by the Adult and Community Care Services Branch.

Signature of Patient or Legal Guardian of Patient _____ Date _____

Diagnosis: _____

_____

Medications: (specify) _____

_____

Special Diet: (specify) _____

_____

Medical/Assistive Equipment: (specify) _____

_____

Other Comments: _____

_____

Estimate Date of Onset of Disability: _____ / _____ / _____
Month Date Year

Indicate Date Disability Will End, if known: _____ / _____ / _____
Month Date Year

Probable Duration of Disability: ☐ Temporary: _____ months

☐ More than one year

☐ Permanent

After each function listed below, indicate the individual's capacity by marking an "X" in the appropriate column. Note: "full" capacity means no significant impairment of function. As necessary, provide additional description in space provided under "Other Comments" on page 1.

Functions	CAPACITY			Functions	CAPACITY		
	Full	Partial	None		Full	Partial	None
Standing				Pushing			
Sitting				Pulling			
Kneeling				Upper Limb Mobility: Left Arm			
Bending from waist				Left Hand			
Walking				Right Arm			
Climbing: Legs Only				Right Hand			
Light Lifting: Under 15 lbs.				Reaching Above Shoulder			
Moderate Lifting: 15-44 lbs.				Speech Articulation			
Heavy Lifting: 45 lbs. & over				Operation of Motor Vehicle			

_____

PRINT: Name of Physician, Physician Assistant (PA), or Advanced Practice Registered Nurse (APRN)

_____ _____

Signature of Physician, PA, or APRN Date

_____ _____ _____

Address City Zip Code

_____

Telephone Number

State of Hawaii
DEPARTMENT OF HUMAN SERVICES
Social Services Division

Return Address Department of Human Services Social Services Division
ADULT INTAKE UNIT DEPARTMENT OF HUMAN SERVICES SOCIAL SERVICES DIVISION 420 WAIAKAMILO ROAD, SUITE 202 HONOLULU, HAWAII 96817-

APPLICATION FOR SOCIAL SERVICES

INSTRUCTIONS FOR APPLYING FOR SOCIAL SERVICES

1. To receive social services you must complete this application form and return it to the Department of Human Services as soon as possible. **Be sure to sign and date this application on Page 5.** If you do not return this application form and the required verification information indicated on Page 2 to the Department within 30 calendar days from the date you signed and dated the form, you will be required to reapply by completing another application form.
2. Your request for help is official only when this application form is received by the Department. You may mail or bring in the completed application form yourself. If the form is not completed properly, you will be asked to fill in any missing information or to correct wrong information before the Department accepts your application.
3. If you have any questions about completing this application, call _____ and ask for _____.
   (Phone Number) (Name of Social Worker or Receptionist)
4. You may also ask a friend or relative to help you to complete this application form. If someone else fills out this application form for you, be sure to have that person sign his or her name in the space provided on Page 5.
5. After you turn in this application form, someone from the Department will contact you. You will be told what has to be done in order to make a decision on your request for social services.
6. A decision on your request will be made within 30 days from the date of your application.
7. Payments for service costs can be approved only from the date of your application.
8. Please print your information. **DO NOT FILL IN THE SHADED SECTIONS.**

CHECK (✓) BELOW ALL THE SERVICES NEEDED NOW BY YOU OR ANOTHER MEMBER OF YOUR FAMILY:

____ Chore/Homemaker ____ Adult Day Care ____ Transportation Assistance for Return to Homeland

____ Adult Foster Care (Adult Residential Care Home) ____ Child Foster Care Board Payments

____ Other (Explain): _____

REASON FOR ASKING FOR HELP: _____

_____

_____

NOTICE TO APPLICANTS:

You must submit all of the following information within thirty (30) days of the date your Application for Services is received. To be considered complete, the following information must be provided:

- Your residence and mailing addresses must be complete.
- You must list the names of family members in the home including, at least, the names, birthdates, Social Security account numbers, and whether anyone receives any type of state of federal financial assistance, such as AFDC, GA, AABD or SSI, or medical assistance through our department. If you are applying for a child who lives away from home, a separate application must be made for the child.
- IF YOU DO NOT RECEIVE ANY TYPE OF STATE OR FEDERAL FINANCIAL ASSISTANCE, OR MEDICAL ASSISTANCE, INFORMATION OF ANY INCOME MUST HAVE VERIFICATION, INCLUDING THE FOLLOWING:
  - WAGES AND SALARIES: Pay stubs covering all pay periods for the past two consecutive months, or a signed statement by your employer on company letter head giving gross monthly pay for the past two consecutive months, or a signed statement by your employer of anticipated gross monthly earnings if you have just started working.
  - GOVERNMENT BENEFITS: Award letters or copies of award letters, or a signed statement by an official of the government agency on agency letterhead giving benefit amount, or a copy of benefit payment.
  - NON-GOVERNMENTAL BENEFITS: Award letters or copies, or signed statement by a company official on company letter head giving the benefit amount.
  - ALIMONY/CHILD SUPPORT: Copy of the court order, or statement of the court clerk, or signed and dated statement of the parent/ex-spouse making payments.
  - ESTATE OR TRUST INCOME: Signed and dated statements of the executor or trust officer.
  - SELF-EMPLOYMENT OR RENTAL PROPERTY INCOME: Gross Income tax forms or copies.
  - INTERESTS OR DIVIDENDS: Bank statements, stockholders' statements, or copies of bank or stock statements, copies of bonds.
- If you are an adult in need of Chore Services for Adults, or Adult Day Care Services, you must submit a statement from a psychologist or physician licensed to practice in Hawaii which gives your diagnosis, prognosis and the specific reason(s) you cannot manage without the service. A general statement of disability without showing its relationship to the service(s) sought is not sufficient.

State of Hawaii
DEPARTMENT OF HUMAN SERVICES

APPLICATION FOR SOCIAL SERVICES

Social Services Division

Print your current address. If you now live in a foster home or some other facility, use that address.

RESIDENCE ADDRESS: Street Number and Name	Apt No.	City:	Zip	Home Phone:
MAILING ADDRESS:		City:	Zip:	Other Phone:

If you came to Hawaii from another state or country, please complete this section, otherwise leave blank.	Arrival Date:	Citizenship (Country):	Prior Residence:

List all family members now living in your home.

Name: First / M.I. / Last	Relationship	Sex M or F	Birthdate	Race	Marital Status	Social Security Account Number
Head of Household						
Spouse						
Child						
Child						
Child						
Child						
Child						
Child						
Child						
Other Adult						
Other Adult						
Other Adult						

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Worker No.:	Worker Name:	Unit:	Area:	Case Number:	Case Name: Last, First, M.I.	Application Date: Date DHS 1501 Mailed or Given:	Date DHS 1501 Received by DHS:

To be completed by Teleprocessing Operator after Master File search.

Case Number:	Stat:	Date:	Unit:	Wkr:	Case Number:	Stat:	Date:	Unit:	Wkr:

State of Hawaii
DEPARTMENT OF HUMAN SERVICES

APPLICATION FOR SOCIAL SERVICES

Social Services Division

If the applicant or applicant's spouse is receiving any type of state or federal financial assistance, such as AFDC, GA, AABD or SSI, or medical assistance through our department, please enter the name of the recipient and the type of assistance. (Please use a separate sheet of paper if additional space is needed.)

Name:	Type of Assistance:
Name:	Type of Assistance:
Name:	Type of Assistance:

IF APPLICANT OR APPLICANT'S SPOUSE HAS BEEN LISTED IN THIS SECTION AS RECEIVING FINANCIAL OR MEDICAL ASSISTANCE, SKIP SECTION BELOW AND GO TO NEXT PAGE.

Check Yes or No for each line of items 1 through 13.d. below. **DO NOT SKIP ANY ITEM**

TYPE OF INCOME		Check (✓) every line below: Yes	No	Gross Amount Before Deductions	Check (✓) how often income is received: Weekly	Every Other Week	Monthly	Twice Per Month
1. Wages and Salaries (Attach last 2 months of pay stubs. Do Not skip any month.)	Name of Wage Earner							
	Name of Wage Earner							
2. Social Security Benefits Claim Number:								
3. Unemployment Compensation Benefits								
4. Workmen's Compensation								
5. Pension or Retirement Pay								
6. Veteran's Benefits Claim								
7. Servicemen's Allotment								
8. Alimony/Child Support								
9. Assistance Payment from Another State								
10. Income from an Estate or Trust Fund								
11. Self-Employment Income (Net)								
12. Net Income from Rental or Other Property Investments								
13. Interests and Dividends from the following resources:								
a. U.S. Savings Bonds								
b. Stockholding								
c. Savings								
d. Others, Specify:								

FOR OFFICIAL USE ONLY	
Calculated Monthly Total Income	Source of Verification
Total:	Who's Init. & Date:

READ AND SIGN

I hereby apply for services and certify that all the information I am giving to the Department on this form and elsewhere is true and correct to the best of my knowledge and that no facts have been omitted. I make this application with the understanding that I will give any additional information which may be needed and will allow the Department to verify my statements either with me or through other sources as necessary.

I fully understand and accept my responsibility to report changes in my situation including changes in my income within 30 days. Furthermore, I understand that if I fail to report changes and receive services to which I am not entitled, the amount of overpayment will be collected from me, and I may be prosecuted for fraud.

I understand that I have a right to appeal for a review and fair hearing if I do not agree with the Department's decision on my application for services.

Applicant's Signature: _____ Date: _____

If applicant is unable to complete and sign the application, then the person filling in this form must sign below.

Representative's Signature: _____ Date: _____

(Representative, please print your name: _____)

Address of Agency: _____ Phone: _____

_____

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ELIGIBILITY DISPOSITION

____ APPROVED:
- ____ Currently receiving AFDC, GA, or AABD benefits
- ____ Currently receiving SSI benefits
- ____ Currently receiving DHS medical benefits
- ____ Family income $ _____ less than DHS Income Standard

____ DENIED:
- ____ Family income $ _____ more than DHS Income Standard
- ____ Other reason(s): _____

____ DISCONTINUED: Reason: _____

_____

COMPUTATION
For Eligibility Determination

Household Size: _____

DHS Income Standard: _____

Family Income: - _____

DIFFERENCE: _____

PRESUMPTIVE ELIGIBILITY NOTICE

The Department of Human Services has thirty (30) days from the day we receive your application to determine whether you are eligible or ineligible for social services. If the Department does not make a decision by the thirtieth (30th) day, the Department must declare you presumptively eligible on the thirty-first (31st) day and so inform you. This means that the Department will pay for the services available through the Department which you applied for and receive from the thirty-first (31st) day, according to the Department's rate of payment, if you present a bill or receipt for the service. The time period between the thirty-first (31st) day and the day the Department makes a final decision on whether or not you are eligible for social services is called the presumptive eligibility period.

1. When, within the presumptive eligibility period, the Department determines you are eligible, the Department will pay for the available services you applied for and received from the day we received the application if you submit a bill or receipt for the service.

2. When, within the presumptive eligibility period, the Department determines you are ineligible or you withdraw your application, you will receive notice of this action. Any service payments being made will stop three days from the day the notice is mailed to you. Your presumptive eligibility will end that third day also. This means that, three days from the date the notice is mailed, you will be responsible for paying for any services you receive.

   If you feel that the Department should not have determined you ineligible or that you did not withdraw your application, you may request a Fair Hearing. Although no service payments will be made while the hearing decision is pending, the Department will pay for all the service costs you applied for from the date of application if you present a bill or receipt for the services and if the hearing decision is in your favor. If the hearing decision is not in your favor, you will remain ineligible and you will be responsible to pay for any services received three days from the date the notice of your ineligibility is mailed as well as for services received before the presumptive eligibility period.

You will be informed of the Department's decision on your eligibility or ineligibility for social services within fifteen (15) days of the date the decision is made.

FAIR HEARING RIGHT

Every applicant for or recipient of social services shall have the opportunity for a fair hearing if dissatisfied with any Department action affecting the applicant or recipient.

A request for a fair hearing must be in writing and must state that you want a hearing and why you are dissatisfied. The local office will give you the Department's form for a fair hearing or you can write your request on any other paper. The local office can help you complete your request for a fair hearing. Your request for a hearing must be received by the Department within ninety (90) days of the date of the Department's notice to you regarding its action.

At the fair hearing, you have the right to be represented by a lawyer, friend, relative, or any other person you wish. If you wish, the Department can give you information about a local Legal Aid Office or community agency which will provide advice or representation at no cost.

NON-DISCRIMINATION IN SERVICE

We provide access to our programs and activities without regard to race, color, national origin (including language), age, sex, religion, or disability. If you feel you have been discriminated against, write: Civil Rights Compliance Officer, P.O. Box 339, Honolulu, Hawaii 96809-0339 or call at 586-4966 (voice) or 586-5959 (TDD) within 180 days of a problem.