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Page	2				

	State:	Rewell			
Agency* Citation(s)	Groups Covered			
	A	Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)			
		2. Desmed Recipients of AFDC			
902 (a)(10)(A)(i)(i) f the Act		b. Effective October 1, 1990, participants in a work supplementation program under title IV-A and any child or relative of such individual (or other individual living in the same household as such individuals) who would be eligible for AFDC if there were no work supplementation program, in accordance with section 482 (c)(6) of the Act.			
12 (a)(22)(A) The Act		c. Individuals whose AFDC payment are reduced to zero by reason of recovery of overpayment of AFDC funds.			
6(h) and 62(a)(10)(A) (I) of the Act		d. An assistance unit deemed to be receiving AFDC for a period of four calendar months because the family becomes ineligible for AFDC as a result of collection or increased collection of support and meets the regularements of section 406(h) of the Act.			
02(a) of a Act		e. Individuals deemed to be receiving AFDC who meet the requirements of section 473(b)(1) or (2) for whom an adoption assistance agreement is in effect or foster care maintenance payments are being made under title IV-E of the Act.			
		* See Supplement 15 to Attachment 2.6-A for eligibility under section 1931 of the Act.			

- Revience

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• Agency that determines eligibility for coverage.

TN No. <u>97-003</u> Seperades TN No. <u>91-21</u> Approved Date

Effective Date

JUL 1 1997

Revision:	HCFA-PM-91-4 August 1991	(BPD)	
	AUGUST 1991		

ATTACHMENT 2.2-A Page 2a OMB NO.: 0938-

State: HAWAII

Agency* Citation(s)

Groups Covered

A. <u>Mandatory Coverage - Categorically Needy and Other</u> <u>Required Special Groups</u> (Continued)

- 407(b), 1902 (a)(10)(A)(1) and 1905(m)(1) of the Act
- 3. Qualified Family Members

Effective October 1, 1990, qualified family members who would be eligible to receive AFDC under section 407 of the Act because the principal wage earner is unemployed.

 \overline{X} Qualified family members are not included because cash assistance payments may be made to families with unemployed parents for 12 months per calendar year.

1902(a)(52) and 1925 of the Act 4. Families terminated from AFDC solely because of earnings, hours of employment, or loss of earned income disregards entitled up to twelve months of extended benefits in accordance with section 1925 of the Act. (This provision expires on September 30, 1998.)

TN No. 91-21	Approval Date	10/13/92	Effective	Date 10/01/91
Supersedes TN No. 88-15			HCFA ID:	7983E

Revision: HCFA-PH-92-1 (MB) FEBRUARY 1992

on page Za,

ATTACHMENT 2.2-A Page 5

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

States HAWAII

11.

COVERAGE AND CONDITIONS OF BLIGIBILITY

Citation(*)

1902(a)(10)

1902(e)(5)

of the Act

1902(e)(6)

of the Act

Act

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(A)(1)(V) and 1905(m) of the

per mRM 92-10.

Groups Covered

Mandatory Coverage - Categorically Needy and Other λ. Required Special Groups (Continued)

- Individuals other than gualified pregnant women 10. and children under item A.7. above who are members of a family that would be receiving AFDC under section 407 of the Act if the State Duplicates item A.3 had not exercised the option under section 407 (b)(2)(B)(1) of the Act to limit the number o months for which a family may receive AFDG.
 - × 8. A woman who, while pregnant, was eligible for, applied for, and receives Medicaid unde. the approved State plan on the day her pregnancy ends. The woman continues to be eligible, as though she were pregnant, for all pregnancy-related and postpartum medical assistance under the plan for a 60-day perior (beginning on the last day of her pregnancy) and for any remaining days in the month in which the 60th day falls.
 - **b**. A pregnant woman who would otherwise lose eligibility because of an increase in income (of the family in which she is a member) during the pregnancy or the postpartum period which extends through the end of the month is which the 60-day period (beginning on the last day of pregnancy) ends.

TN No. 92-15 Supersedes Approval Date _10/29/92 Effective Date 7/1/92 TN No. 88-16

(MB)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State:	HAWAII
Citation(s)	Groups Covered
	A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)
1902(e)(4) of the Act	12. A child born to a woman who is eligible for and receiving Medicaid-as categorically needy on the date of the child's birth. The child is deemed eligible for one year from birth as long as the mother remains eligible or would remain eligible if still pregnant and the child remains in the same household as the mother.
42 CFR 435.120	13. Aged, Blind and Disabled Individuals Receiving Cash Assistance
	a. Individuals receiving SSI.
	This includes beneficiaries' eligible spouses and persons receiving SSI benefits pending a final determination of blindness or disability or pending disposal of excess resources under an agreement with the Social Security Administration; and beginning January 1, 1981 persons receiving SSI under section 1619(a) of the Act or considered to be receiving SSI under section 1619(b) of the Act.
	Aged
	Blind
	Disabled
Agency that determines eligibility	

TN No.00-006SupersedesApproval Date: JUL 1 1 2000Effective Date:APR 1 2000TN No.88-16HCFA ID: 7983E

Revision:

HCFA-PM-91-4 (BPD) August 1991

ATTACHMENT 2.2-A Page 6a OMB NO.: 0938-

42 CFR 435.120 13. 2 b. 1 13. 9 b. 1 13. 9 b. 1 13. 9 b. 1 14. 1 15. 1 15. 1 15. 1 16. 1 17. 1 17. 1 17. 1 18. 1 19. 1 1	rage – Categorically Needy and Other Groups (Continued) ndividuals who meet more restrictive equirements for Medicaid than the SSI equirements. (This includes persons w ualify for benefits under section 1619(a f the Act or who meet the requirements for SI status under section 1619(b)(1) of the
42 CFR 435.120 13. 2 b. 1 r r q or Si A re	ndividuals who meet more restrictive equirements for Medicaid than the SSI equirements. (This includes persons w ualify for benefits under section 1619(a f the Act or who meet the requirements for
I.S. MEL B. I r q o Si A re	equirements for Medicaid than the SSI equirements. (This includes persons w ualify for benefits under section 1619(a f the Act or who meet the requirements for
re	Ct and who most the $\Omega_{1,1}$ is $\Omega_{1,1}$ of the
rea Ac inc co sta	ct and who met the State's more strictive requirements for Medicaid in the onth before the month they qualified for 51 under section 1619(a) or met the quirements under section 1619(b)(1) of the tet. Medicaid eligibility for these lividuals continues as long as they nation to meet the 1619(a) eligibility indard or the requirements of section 19(b) of the Act.)
	zd
J Blir	ıd
J Disa	bled
The crite	more restrictive categorical eligibility ria are described below:
* De C.1	finition of disability as defined in 42 F.R. 435.540 and 435.541
* De C.I	finition of blindness as defined in 42 R. 435.530 and 435.531

TN No.01-011SupersedesApproval Date:DEC2 0 2001TN No.00-006HCFA ID:7983E

Revision: HCFA-PM-91-4 August 1991

(BPD)

ATTACHMENT 2.2-A Page 6b OMB NO : 0038

			OMB NO.: 0938-
0*	State:	HAV	WAII
Agency*	Citation(s)		Groups Covered
	А.	Mandatory C Required Spe	overage – Categorically Needy and Other cial Groups (Continued)
1902(a) (10)(A) (i)(II)	e e e e e e e e e e e e e e e e e e e	14. Quali	fied severely impaired blind and disabled duals under age 65, who
and 1905 of(q) of he Act		a. .	For the month preceding the first month of (q) eligibility under the requirements of section 1905(q)(2) of the Act, received SSI, a State supplemental payment under section 1616 of the Act or under section 212 of P.L. 93-66 or benefits under section 1619(a) of the Act and were eligible for Medicaid; or
	•	b.	For the month of June 1987, were considered to be receiving SSI under section 1619(b) of the Ac and were eligible for Medicaid. These individuals must
		(1)	Continue to meet the criteria for blindness or have the disabling physical or mental impairment under which the individual was found to be disabled;
		(2)	Except for earnings, continue to meet all nondisability-related requirements for eligibility for SSI benefits;
		(3)	Have unearned income in amounts that would not cause them to be ineligible for a payment under section 1611(b) of the Act;
ŝ.			

TN No.	00-006		 		
Supersedes TN No.	86-16	Approval Date: JUL	Effective Da HCFA ID:	1 2000	

Revision: HCFA-PM-91-4 August 1991

(BPD)

ATTACHMENT 2.2-A Page 6c OMB NO · 0038

8 a			OMB NO.: 0938-
	State:	HAWA	<u>II</u>
Agency*	Citation(s)	(Groups Covered
и	А.	Mandatory Cove Required Specia	rage – Categorically Needy and Other I Groups (Continued)
	· ·	(4)	Be seriously inhibited by the lack of Medicaid coverage in their ability to continue to work or obtain employment; and
		(5)	Have earnings that are not sufficient to provide for himself or herself a reasonable equivalent of the Medicaid, SSI (including any Federally administered SSP), or public funded attendant services that would be available if he or she did have such earnings.
			Not applicable with respect to individuals receiving only SSP because the State either does not make SSP payments or does not provide Medicaid to SSP-only recipients.
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TN No. 00-006		
Supersedes TN No. 86-16	Approval Date: UL 11 2000 Effect	

Revision:	HCFA-PM-91-4 AUGUST 1991 State:H	(BPD) Awaii	ATTACHAENT 2.2-A Page 6d OMB NO.: 0938-
Agency*	Citation(S)	Group	os Covered
1619(of th	A. b)(3) <u>(X</u> / e Act ;	Required Special Group The State applies more requirements for Medie under 42 CFR 435.121. benefits under section individuals described requirements for SSI 1619(b)(1) of the Act restrictive requireme month they qualified met the requirements are covered. Eligibi continues as long as	e restrictive eligibility caid than under SSI and Individuals who qualify for n 1619(a) of the Act or above who meet the eligibility

TN No. 91-21	Approval Date	10/13/92	Effective	Date	0/01/91
Supersedes			HCFA ID:	79832	
TN No.					

evision:	HCFA-PM-91- AUGUST 1991	4 (BPD)	ATTACHMENT 2.2-A Page 60 Omb No.: 0938-
	state:	HAWAII	
gency*	Citation(S)		Groups Covered
	λ.	Required Special	<u>e - Categorically Needy and Other</u> Groups (Continued)
1634() the A	c) of ct	15. Except in Stat eligibility re SSI, blind or	es that apply more restrictive quirements for Medicaid than under disabled individuals who
	- 1	a. Are at leas	t 18 years of age;
		entitled to section 20 these bene Medicaid e continues for SSI, a	ligibility because they become o OASDI child's benefits under 2(d) of the Act or an increase in fits based on their disability. ligibility for these individuals for as long as they would be eligibl beent their OASDI eligibility.
		requirement all of the caused SSI	applies more restrictive eligibility ts than those under SSI, and part or amount of the OASDI benefit that /SSP ineligibility and subsequent are deducted when determining the countable income for categorically ibility.
		1 d. The State	applies more restrictive requirement under SSI, and none of the OASDI deducted in determining the amount ole income for categorically needy
42 0	FR 435.122	eligibility SSI, individ optional Sta Medicaid und that do not	ates that apply more restrictive requirements for Medicaid than under uals who are ineligible for SSI or te supplements (if the agency provide er \$435.230), because of requirement: apply under title XIX of the Act.
	CFR 435.130	17. Individuals	receiving mandatory State supplement
+Agency	that determ:	ines eligibility for	coverage.
TN No. Superse	91-21	Approval Date 10/13	

Revision:	HCFA-PM-91-4	(BPD)
Revision:	HCFA-PM-91-4 August 1991	(BPU)

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21	. 8			And in case of the local division of the loc

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Agency* Citation(s)

Groups Covered

A. <u>Mandatory Coverage - Categorically Needy and Other</u> Required Special Groups (Continued)

42 CFR 435.131

- Individuals who in December 1973 were eligible for Medicaid as an essential spouse and who have continued, as spouse, to live with and be essential to the well-being of a recipient of cash assistance. The recipient with whom the essential spouse is living continues to meet the December 1973 eligibility requirements of the State's approved plan for OAA, AB, APTD, or AABD and the spouse continues to meet the December 1973 requirements for having his or her needs included in computing the cash payment.
- 1X/ In December 1973, Medicaid coverage of the essential spouse was limited to the following group(s):

X Aged X Blind X Disabled

 \Box

Not applicable. In December 1973, the essential spouse was not eligible for Medicaid.

*Agency that determines that	Effective Date 10/01/
TN No. 91-21 Approval Date 10/13/92 Supersedes	HCFA ID: 7983E
TN No.	

Revision:	HCFA-PM-91- AUCUST 1991	4 (BPD)	Page	HMENT 2.2-A 6g 0.: 0938-
	State:	HAWAII		
Agency	Citation(#)		Groups Covered	
	۰.	Required S	overage - Categorically Nee ecial Groups (Continued)	
42 CE	R 435.132	for	tutionalized individuals wh Medicaid in December 1973 as XIX medical institutions of	residents of
			XIX medical institute care faci consecutive month after Dec	lities, if, for
		a. C S	ontinue to meet the December tate plan eligibility requir	1973 Medicaid rements; and
		ь. я	emain institutionalized; and	1
		c. 0	ontinue to need institution	al care.
A2 C	FR 435.133	20. Blir	d and disabled individuals	who
			est all current requirements ligibility except the blinds riteria; and	s for Medicaid ness or disability
		b . 1	ere eligible for Medicaid i blind or disabled; and	n December 1973 as
22			for each consecutive month a continue to meet December 19 criteria.	fter December 1973 73 eligibility

TN No. 91-21	Approval Date	-10/13/92-	Effective	Date
Supersedes			HCFA ID:	7983E
TH NO.				

Revision:	HCFA-PM-91-4 August 1991	(BPI	D) ATTACHMENT 2.2-A Page 7 OMB NO.: 0938-
	State:	HAWAII	
Agency*	Citation(S)		Groups Covered
	A.]	Mandatory Required	<u>Coverage - Categorically Needy and Other</u> <u>Special Groups</u> (Continued)
42 CFF	1	for 92-	ividuals who would be SSI/SSP eligible except the increase in OASDI benefits under Pub. L. -336 (July 1, 1972), who were entitled to OASDI August 1972, and who were receiving cash sistance in August 1972.
			Includes persons who would have been eligible for cash assistance but had not applied in August 1972 (this group was included in this State's August 1972 plan).
	-		Includes persons who would have been eligible for cash assistance in August 1972 if not in a medical institution or intermediate care facility (this group was included in this State's August 1972 plan).
		<u>/x</u> 7	Not applicable with respect to intermediate care facilities; the State did or does not cover this service.

TN No. 91-21	Approval Da	te 10/13/92	Effective	Date 10/01/91
Supersedes TN No. 88-16			HCFA ID:	79832

Revision: HCFA-PM-91-4 (BPD) AUGUST 1991

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HAWAII State:__

Citation(s) Agency*

Groups Covered

A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

42 CFR 435.135

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- Individuals who ---22.
 - Are receiving OASDI and were receiving SSI/SSI **a**. but became ineligible for SSI/SSP after April 1977; and
 - Would still be eligible for SSI or SSP if Ъ. cost-of-living increases in OASDI paid under section 215(1) of the Act received after the last month for which the individual was eligible for and received SSI/SSP and OASDI, concurrently, were deducted from income.
 - Not applicable with respect to individuals \Box receiving only SSP because the State eithe does not make such payments or does not provide Medicaid to SSP-only recipients.
 - Not applicable because the State applies 11 more restrictive eligibility requirements than those under SSI.
 - The State applies more restrictive <u>/X7</u> eligibility requirements than those under SSI and the amount of increase that caused SSI/SSP ineligibility and subsequent increases are deducted when determining th amount of countable income for categorica; needy eligibility.

TN No. 91-21	Approval Date	10/13/92 Effective	Dete 10/01/91
Supersedes TN No. 87-17		HCFA ID:	7903E

Revision:	HCFA-PM-91- August 1991		ATTACHMENT 2.2-A Page 9 OMB NO.: 0938-
	State:	HAWAII	
Agency*	Citation(S)	Gz	coups Covered
	λ.	<u>Mandatory Coverage - (Required Special Group</u>	Categorically Needy and Other De (Continued)
1634 Act	of the	eligible for SS in their OASDI elimination of section 134 of for purposes of or SSP benefici eligible for SS the Act.	and widowers who would be I or SSP except for the increase benefits as a result of the the reduction factor required by Pub. L. 98-21 and who are deemed, title XIX, to be SSI beneficiaries aries for individuals who would be P only, under section 1634(b) of
3		receiving on does not mak provide Medi	ble with respect to individuals aly SSP because the State either the these payments or does not loaid to SSP-only recipients.
		<u>(X</u>) The State and standards the these indivi- SSI Federal rate for in	pplies more restrictive eligibility han those under SSI and considers iduals to have income equalling the benefit rate, or the SSP benefit dividuals who would be eligible for hen determining countable income for tegorically needy eligibility.

*Agency that determines eligibility for coverage.

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TN No. 91-21	Approval Date 10/13/92	Effective Date10/01/91
Supersedes TN No. 89-7		HCFA ID: 7983E

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Agency*	Citation(S)				Groups Covered
1634(d) Act	of the	۸.	Hand	atory o	Coverage - Categorically Needy and Other Mecial Groups (Continued)
11	,		24.	unmary to the least effect are re of the eligib in the began eligib title	ed widows, disabled widowers, and disable ied divorced spouses who had been marrie insured individual for a period of at ten years before the divorce became ive, who have attained the age of 50, who ceiving title II payments, and who becau receipt of title II income lost ility for SSI or SSP which they received month prior to the month in which they to receive title II payments, who would be for SSI or SSP if the amount of the II benefit were not counted as income, a we not entitled to Medicare Part A.
				·	The State applies more restrictive eligibility requirements for its blind disabled than those of the SSI program.
	x			<u> </u>	In determining eligibility as categorically needy, the State disregar the amount of the title II benefits identified in § 1634(d)(1)(A) in determining the income of the individua but does not disregard any more of this income than would reduce the individual income to the SSI income standard.
					In determining eligibility as categorically needy, the State disregar only part of the amount of the benefits identified in \$1634(d)(1)(A) in determining the income of the individua which amount would not reduce the individual's income below the SSI income standard. The amount of these benefits to disregarded is specified in Supplement 4 to Attachment 2.5-A.
					In determining eligibility as categorically needy, the State chooses not to deduct any of the benefit "identified in § 1634(d)(1)(A) in determining the income of the individual

TN No. <u>91-21</u> Supersedes TN No. Approval Date ______10/13/92 Effective Date 10/01/91

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	State:		HAWAII			
Agency*	Citation(s)		Groups Covered			
		A. M <u>R</u>	andatory Coverage - Categorically Needy and Othe equired Special Groups (Continued)			
1902(a)(1		2	5. Qualified Medicare beneficiaries			
and 1905() the Act	p) or _		a. Who are entitled to hospital insurance benefits under Medicare Part A, (but no pursuant to an enrollment under section 1818) of the Act);			
			b. Whose income does not exceed 100 percent of the Federal poverty level; and			
· ·			C. Whose resources do not exceed twice the maximum standard under SSI.			
			(Medical assistance for this group is limited to Medicare cost-sharing as defined in item 3.2 of this plan.)			
1902(a)(10		20	. Qualified disabled and working individuals			
1905(s) an 1905(p)(3) of the Act	(A)(1)		a. Who are entitled to hospital insurance benefits under Medicare Part A under section 1818A of the Act;			
			b. Whose income does not exceed 200 percent of the Federal poverty level; and			
			c. Whose resources do not exceed twice the maximum standard under SSI.			
° se			d. Who are not otherwise eligible for medical assistance under Title XIX of the Act.			
			(Medical assistance for this group is limited to Medicare Part A premiums under section 1818A of the Act.)			
Beenew AL	at datamine	a] { a {	bility for coverage.			

No. 93-03 Supersedes Approval Date 5/3/93 Effective Date 1/1/93 TN No. 91-21 Revision: HCFA-PM- -

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ATTACHMENT 2.2-A Page 9b1

	State:	H	AWAII	<u> </u>
Agency*	Citation(s)	н 1. т. ц.		Groups Covered
	,	. Man	dato	ry Coverage - Categorically Needy and Other d Special Groups (Continued)
1902(a)(1 and 1905(of the Ac	0(B)(iii) p)(3)(A)(ii) t	27.	Spe a.	Who are entitled to hospital insurance benefits under Medicare Part A (but not pursuant to an enrollment under section 1818A of the Act);
			b.	Whose income for calendar years 1993 and 1994 exceeds the income level in 25. b., but is less than 110 percent of the Federal poverty level, and whose income for calendar years beginning 1995 is less than 120 percent of the Federal poverty level; and
			с.	Whose resources do not exceed twice the maximum standard under SSI.
			Med.	dical assistance for this group is limited to icare Part B premiums under section 1839 of Act.)

No				TN
No. <u>93-03</u> Supersedes TN No. 91-21	Approval Date	5/3/93	Effective Date	1/1/93
TN No. 91-21	_			

Revision:	HCFA-PM-95-2	(MB)
	APRIL 1995	• •

ATTACHMENT 2.2-A Page 9b2

Agency*	Citation(s)		Groups Covered				
		А.	Mandu Requi	Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)			
	1634(e) of the Act		28.	۵.	Each person to whom SSI benefits by reason of disability are not payable for any month solely by reason of clause (i) or (v) of Section 1611(e)(3)(A) shall be treated, for purposes of title XIX, as receiving SSI benefits for the month.		
8	k		<u>X</u>	b.	The State applies more restrictive eligibility standards than those under SSI.		
					Individuals whose eligibility for SSI benefits are based solely on disability who are not payable for any months solely by reason of clause (i) or (v) of Section 1611(e)(3)(A), and who continue to meet the more restrictive requirements for Medicaid eligibility under the State plan, are eligible for Medicaid as categorically needy.		

*Agency that determines eligibility for coverage.

TN No. 96-006 Supersedes 95-00 Approval Date 620 96 Effective Date 2196 Revision: HCFA-PM-91-4 (BPD) AUGUST 1991 ATTACHMENT 2.2-A Page 9c OMB No.: 0938-

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Agency*	Citation(s)	Groups Covered
	B. Q	ptional Groups Other Than the Medically Needy
	42 CFR /X/ 1 435.210 1902(a) (10)(A)(11) and 1905(a) of the Act	. Individuals described below who meet the income and resource requirements of AFDC, SSI, or an optional State supplement as specified in 42 CFR 435.230, but who do not receive cash assistance.
	•	The plan covers all individuals as described above.
63		/X/ The plan covers only the following group or groups of individuals:
		X Aged X Blind X Disabled X Caretaker relatives X Pregnant women
	42 CFR (X7 : 435.211	Individuals who would be eligible for AFDC, SSI or an optional State supplement as specified in 42 CFR 435.230, if they were not in a medical institution.

TN No. <u>91-21</u> Supersedes	Approval Date 10/13/92	Effective Date 10/01/91
Supersedes TN No. 89.07	•	HCFA ID: 79838

Revision: HCFA-PM-91-10 December 1991

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(BPD)

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Decemb	er 1991	Page 10
	State:	HAWAII
Agency*	Citation(s)	Groups Covered
2 CFR 435.212 & 902(e)(2) of the act, P.L. 99-272 section 9517) P.L. 01-508 (section 732)	B. <u>Op</u> (Cc	tional Groups Other Than the Medically Needy Intinued) The State deems as eligible those individuals who became otherwise ineligible for Medicaid while enrolled in an HMO qualified under Title XIII of the Public Health Service Act, or a managed care organization (MCO), or a primary care case management (PCCM) program, but who have been enrolled in the entity for less than the minimum enrollment period listed below. Coverage under this section is limited to MCO or PCCM services and family planning services described in section 1905(a)(4)(C) of the Act.
	<u>_x</u> 	 The State elects not to guarantee eligibility. The State elects to guarantee eligibility. The minimum enrollment period is months (not to exceed six). The State measures the minimum enrollment period from: [] The date beginning the period of enrollment in the MCO or PCCM, without any intervening disenrollment, regardless of Medicaid eligibility.
		[] The date beginning the period of enrollment in the MCO or PCCM as a Medicaid patient (including periods when payment is made under this section), withou any intervening disenrollment.
	4	[] The date beginning the last period of enrollment in the MCO or PCCM as a Medicaid patient (not including periods whe payment is made under this section) without any intervening disenrollment or periods of enrollment as a privately paying patient. (A new minimum enrollment period begins eac time the individual becomes Medicaid eligible other than under this section).

TN No.03-003Aug 1 3Supersedes 1.Approval Date:MAR · 2 2004 Effective Date:TN No.97-21

	December	1991_		Page 10a
		State:	НАЖАП	
Agency*	Ci	tation(s)	Groups	Covered
1932(a)(4)	of the Act	В.	Optional Groups Other The (Continued)	an the Medically Needy
			PAHPs, and PCCMs in acc 42 CFR 438.56. This requirecipient can demonstrate g	enrollees of MCOs, PIHPs, cordance with the regulations a
		-		s are restricted for a ths (not to exceed 12 months).
			period the recipient The State will provi per year, to recipien	e months of each enrollment may disenroll without cause. de notification, at least once ts enrolled with such r right to and restrictions of rollment.
		_	No restrictions upor	disenrollment rights.
903(m)(2)(902(a)(52) Act P.L. 101-508 2 CFR 438.	of the]	Medicaid for the brief period 903(m)(2)(H) and who ser PIHP, PAHP, or PCCM wh	e enrolled with an MCO, en they became ineligible, the to reenroll those individuals in
			entity if they were dis	provide automatic bove individuals into the same senrolled solely because of ibility for a period of 2 months
A games, that	datamina			t to reenroll above individuals a which they were previously
	ucucimines	CIRCUIN	y lui coverage.	
N No. 0. 1 persedes	3-003	Approv	Date: MAR 2 2004	ective Date: AUG 1 3

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Revision:	HCFA-PM-91-1-4 August 1991	(BPD)	ATTACHMENT 2.2-A Page 11 OMB NO.: 0938 -
× <u></u>	State:	HAWAII	
Agency*	Citation(s)	Groups Co	wered
	B.	Optional Groups Other Than the (Continued)	Medically Needy
42 CFR 43:	5.217 X	were in a NF or an ICF, provision of home and under a waiver granted Subpart G would requir who will receive home services under the waiv covered are listed in the option is effective on th State's section 1915(c) group(s) is covered. In 1915(c) waiver is amend	d under the plan if they /MR, who but for the community-based services under 42 CFR Part 441, re institutionalization, and and community-based er. The group or groups waiver request. This e effective date of the waiver under which this

Revision: HCFA-PM-91-4 AUCUST 1991	(BPD)	ATTACHMENT 2.2-A Page 11a OMB NO.: 0938-
State:	HAWAII	
Agency* Citation(8)		Groups Covered
8. <u>Op</u> (C	tional Grou Continued)	ups Other Than the Medically Needy
1902(a)(10) (X7 5. (A)(11)(VII) of the Act	Medicald medical is ill, and accordance	ls who would be eligible for under the plan if they were in a nstitution, who are terminally who receive hospice care in e with a voluntary election described in 905(0) of the Act.
		The State covers all individuals as described above.
48 - 1911 - 19 20 - 29		The State covers only the following group or groups of individuals:
		Aged Blind Disabled Individuals under the age of 21 20 19
		19 Caretaker relatives

Pregnant women

	Approval Date	10/13/92	Effective Date 10/01/91
Supersedes TN No.		-	HCFA ID: 7983E

Revision:	HCFA-PM-91 AUGUST 1991	-4	(BPD)			ATTACHMENT 2 Page 15 OMB NO.: 09:	
	State:	: e: * *	HAWAII				
Agency*	Citation(s)				Groups Cove	ered	
	-2	в.	Optional (Continu	Group ed)	s Other Than 1	the Medically Ne	redy
42 CF	R 435.230		10. <u>St</u>	ctions	sing SSI crite 1616 and 1634	of the Act.	ments under
	а 1		on pa su	ly a S yment) ppleme	tate supplement under an appu ntary payment	of individuals w htary payment () roved optional () program that me The supplement	out no SSI State State
			۹.	Based basis		paid in cash on	a regular
			Ъ.	indiv stand	idual's count	rence between the able income and stermine eligib:	the incom
			с.	Avail	able to all in	ndividuals in th	he State.
			d.	. of in eligi	dividuals list	of the classified below, who was a contract of the local second s	would be
				(1)	All aged ind	ividuals.	
				(2)	All blind in	dividuals.	
				(3)	All disabled	individuals.	

TN No. 91-21 Supersedes Approval Date 10/13/92	Effective Date 10/01/91
TN NO	HCFA ID: 7983E

Revision:	HCFA-PM-91-4 August 1991	(BPD)		ATTACHMENT 2.2-A Page 16
	State:	HAWAII		OMB NO.: 0938-
Agency*	Citation(s)			Groups Covered
	B.	Optional (Continue	Grou ed)	ps Other Than the Medically Needy
			(4)	Aged individuals in domiciliary facilities or other group living arrangements as defined under SSI.
42 CF	R 435.230		(5)	Blind individuals in domiciliary facilities or other group living arrangements as defined under SSI.
			(6)	Disabled individuals in domiciliary facilities or other group living arrangements as defined under SSI.
		•	(7)	Individuals receiving a Federally administered optional State supplement that meets the conditions specified is 42 CFR 435.230.
			(8)	Individuals receiving a State administered optional State supplement that meets the conditions specified is 42 CFR 435.230.
			(9)	Individuals in additional classifications approved by the Secretary as follows:

•

TN No. 91-21 Supersedes TN No. 89-2	Approval	Date	10/13/92	Effective	Date 10/01/91
TN No	,	•		HCFA ID:	7983E

Revision:	НСГА-РМ-91-4	(BPD)
	AUCUST 1991	

1

ATTACHMENT 2.2-A Page 16a OMB NO.: 0938-

State: HAWAII

Agency* Citation(S)

Groups Covered

B. <u>Optional Groups Other Than the Medically Needy</u> (Continued)

The supplement varies in income standard by political subdivisions according to cost-of-living differences.

____ Yes.

No.

The standards for optional State supplementary payments are listed in Supplement 6 of <u>ATTACHMENT</u> 2.6-A.

TN No. 91-21 Supersedes	Approval	Date	10/13/92	Effective	Date	10/01/91
TN No.				HCFA ID:	7983E	Υ.,

.

Revision:	HCFA-PM-91-4 August 1991	(BPD)		ATTACHMENT 2.2-A Page 17 OMB NO.: 0938-
	State:	HAWAII		
Agency*	Citation(8)	29 2 1		Groups Covered
	в	. <u>Optiona</u> (Contin	l Grou ued)	ops Other Than the Medically Needy
42 CFR 435.121 and 435.230 1902(a)(10)(A)		Wi	thout the	1902(f) States and SSI criteria Stat agreements under section 1616 or 161
(ii) (XI) of the ACt	I) of the	e op th	State tiona: at me	lowing groups of individuals who rece supplementary payment under an appro 1 State supplementary payment program ats the following conditions. The ent is
	ť.	a '.	Base basi	i on need and paid in cash on a regul
		b.	indi	to the difference between the vidual's countable income and the inc dard used to determine eligibility for supplement.
	ar.	c.	Avai clas basi	Lable to all individuals in each sification and available on a Statew. S.
		d.	Paid of i	to one or more of the classification ndividuals listed below:
			(1)	All aged individuals.
			(2)	All blind individuals.
	51 (A)		(3)	All disabled individuals.
			æ	
	91-21			

TN No. 91-21 Supersedes	Approval Date	10/13/92	Effective Date 10/01/91
TN No. 88-14			HCFA ID: 7983E

Revision:	HCFA-PM-91-4 AUGUST 1991 State:	(BPD) Hawaii		ATTACHMENT 2.2-A Page 18 OMB NO.: 0938-			
Agency* Citation(8)		Groups Covered					
	B.		1 Grou	IDS Other Than the Medically Needy			
		<u>_X_</u>	(4)	Aged individuals in domiciliary facilities or other group living arrangements as defined under SSI.			
	* * * *	- -	(5)	Blind individuals in domiciliary facilities or other group living arrangements as defined under SSI.			
240		<u>x</u>	(6)	Disabled individuals in domiciliary facilities or other group living arrangements as defined under SSI.			
			(7)	Individuals receiving federally administered optional State supplement that meets the conditions specified in 42 CFR 435.230.			
			(8)	Individuals receiving a State administered optional State supplement that meets the conditions specified in 42 CFR 435.230.			
			(9)	Individuals in additional classifications approved by the Secretary as follows:			

TN No. 91-21 Supersedes	Approval Date _	10/13/92	Effective Date 10/01/91
Supersedes TN No. 87-16			HCFA ID: 7983E

Revision:	HCFA-PM-91-4 August 1991	(BPD)	ATTACHMENT 2.2-A Page 18a OMB NO.: 0938-
24	State:	HAWAII	
Agency*	Citation(8)		Groups Covered
	Β.	Optional Gr (Continued)	oups Other Than the Medically Needy
		politi	pplement varies in income standard by cal subdivisions according to f-living differences.
	1	-	Yes

The standards for optional State supplementary payments are listed in Supplement 6 of <u>ATTACHMENT 2.6-A</u>.

TN No. 91-21 Supersedes	Approval Date 10/13/92	Effective Date 10/01/91
TN No.		HCFA ID: 7983E

Revision:	HCFA-PM-91-4 August 1991	(BP	D) ATTACHMEN: 2.2-A Page 19 OMB No.: 0938-		
	State:	HAWAII			
Agency*	Agency* Citation(s)		Groups Covered		
	B	Optio (Cont	nal Groups Other Than the Medically Needy inued)		
42 CF 1902((A)(1 of th	R 435.231 // a)(10) 1)(V) • Act		Individuals who are in institutions for at least 30 consecutive days and who are eligible under a special income level. Eligibility begins on the first day of the 30-day period. These individuals meet the income standards specified in Supplement 1 to <u>ATTACHMENT 2.5-A</u> .		
	*		The State covers all individuals as described above.		
			The State covers only the following group or groups of individuals:		
(11)	a)(10)(A) and 1905(a) a Act		Aged Blind Disabled Individuals under the age of 21 20 19 19 18 Caretaker relatives Pregnant women		

TN No. 91-21 Supersedes	Approval De	Date 10/13/92	Effective Date 10/01/91	
TN No. 89-3			HCFA ID: 7983E	

Revision:	AUGUST 1991	(BP) Hawa:	Page 20 ONB NO.: 0938-
State:			Groups Covered
Agency*		. <u>Option</u> (Conti	al Groups Other Than the Medically Needy
1902(e of the			Certain disabled children age 18 or under who are living at home, who would be eligible for Medicaid under the plan if they were in a medical institution, and for whom the State has made a determination as required under section 1902(e)(3)(B) of the Ad <u>Supplement 3 to ATTACHMENT 2.2-A</u> describes to method that is used to determine the cost effectiveness of caring for this group of disabled children at home.
1902(4 (A)(1) and 15 of the	L)(IX) 002(1)		The following individuals who are not mandatory categorically needy whose income does not exceed the income level (established at an amount above the mandatory level and not more than 185 percent of the Federal poverty income level) specified in <u>Supplement</u> to ATTACHMENT 2.6-A for a family of the same size, including the woman and unborn child of infant and who meet the resource standards specified in <u>Supplement 2 to ATTACHMENT 2.6-</u>
		۵.	Women during pregnancy (and during the 60-day period beginning on the last day o pregnancy); and
5 4		Ъ.	Infants under one year of age.

	Approval	Date	10/13/92	-	Effective Date 10/01/91
TN No		×		я	HCFA ID: 7983E

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Revision:	AUGUS	PM-91-4 r 1991 ste:	(BF HAWAI	u /=		ATTACHMENT 2.2-A Page 22 OMB NO.: 0938-
Agency*	Citati	.on (s)			Groups Co	vered
		E	(Cont	al Groups nued)	Other Than	the Medically Needy
1902 (127	16.	Individua	ls	
(1) a	X) 902(m) nd (3) e Act	1	a .	are disab section 1 Both aged	bled, as details (3) o	ed individuals are covered
			b.	(establing the Feder Supplement	shed at an a ral income D	t exceed the income level nount up to 100 percent of overty level) specified in CHMENT 2.6-A for a family d
			с.	amount all more rest	llowed under trictive fin	ot exceed the maximum SSI; under the State's ancial criteria; or under y needy program as ENT 2.6-A.

TN No. 91-21 Supersedes	Approval Date	Effective Date 10/01/91
TN No		HCFA ID: 7983E

Revision: H

D: HCFA-PM-91-8 October 1991

(MB)

ATTACHMENT 2.2-A Page 23a OMB NO.:

2

Citation Groups Covered B. Optional Coverage Other Than the Medically Needy (Continued) 1906 of the Act 18. Individuals required to enroll in cost-effective employer-based group health plans remain eligible for a minimum enrollment period of months. 1902(a)(10)(F) and 1902(u)(1) of the Act 19. Individuals entitled to elect COBRA continuation coverage and whose income as determined under Section 1612 of the Act for purposes of the SSI program, is no more than 100 percent of the Federal poverty level, whose resources are no more than twice the SSI resource limit for an individual, and for whom the State determines that the cost of COBRA premiums is likely to be less than the Medicaid expenditures for an equivalent set of services. See		State/Territory: HAWAII				
1906 of the Act 18. Individuals required to enroll in cost-effective employer-based group health plans remain eligible for a minimum enrollment period of months. 1902(a)(10)(F) and 1902(u)(1) 19. Indivuduals entitled to elect COBRA continuation coverage and whose income as determined under Section 1612 of the Act for purposes of the SSI program, is no more than 100 percent of the Federal poerty level, whose resources are no more than twice the SSI resource limit for an individual, and for whom the State determines that the cost of COBRA premiums is likely to be less than the Medicaid expenditures for an equivalent	Citation	9 (e)	Groups Covered			
 Act 13. Individuals required to enroll in cost-effective employer-based group health plans remain eligible for a minimum enrollment period of months. 1902(a)(10)(F) 19. Indivuduals entitled to elect COBRA continuation coverage and whose income as determined under Section 1612 of the Act for purposes of the SSI program, is no more than 100 percent of the Federal poerty level, whose resources are no more than twice the SSI resource limit for an individual, and for whom the State determines that the cost of COBRA premiums is likely to be less than the Medicaid expenditures for an equivalent 		В. <u>Ор</u>	tional Coverage Other Than the Medically Needy (Continued)			
and 1902(u)(1) of the Act income as determined under Section 1612 of the Act for purposes of the SSI program, is no more than 100 percent of the Federal property level, whose resources are no more than twice the SSI resource limit for an individual, and for whom the State determines that the cost of COBRA premiums is likely to be less than the Medicaid expenditures for an equivalent		2**	cost-effective employer-based group health plans remain eligible for a minimum			
Supplement 11 to Attachment 2.6-A.	md 1902(u)(1)		continuation coverage and whose income as determined under Section 1612 of the Act for purposes of the SSI program, is no more than 100 percent of the Federal property level, whose resources are no more than twice the SSI resource limit for an individual, and for whom the State determines that the cost of COBRA premiums is likely to be less than the Medicaid expenditures for an equivalent set of services. See			

ATTACHMENT 2.2-A Page 23c

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State:		HAWAII
		The following reasonable
		classifications of children described
		above who are under age (18 10
	·	with family income at or below the
		percent of the Federal poverty level
		specified for the classification:
		(ADD NARRATIVE DESCRIPTION(S
		OF THE REASONABLE
		CLASSIFICATION(S) AND THE
		PERCENT OF THE FEDERAL
		POVERTY LEVEL USED TO
		ESTABLISH ELIGIBILITY FOR EACH
		CLASSIFICATION.)
e)(12) of the Act	21.	A child under age (not to exceed age
		19) who has been determined eligible is deemed
		to be eligible for a total of months (not to
		exceed 12 months) regardless of changes in
		circumstances other than attainment of the
		maximum age stated above.
of the Ast		
of the Act	22.	Children under age 19 who are determined by
		a quarmed entity" (as defined in
		§1902(b)(3)(A)) based on preliminary
		information, to meet the highest applicable
		income criteria specified in this plan.
		The presumptive period begins on the day that the
		determination is made. If an application for
		Medicaid is filed on the child's behalf by the last
		day of the month following the month in which
		the determination of presumptive eligibility was
		made, the presumptive period ends on the day that
		the State agency makes a determination of
		eligibility based on that application. If an
		application is not filed on the still it is the
		application is not filed on the child's behalf by the
		last day of the month following the month the
		determination of presumptive eligibility was
		make, the presumptive period ends on that last
		day.

1902(

•••

1920A 1902A

TN No. 01-006 Supersedes TN No. 00-004

Q

Approval Date: OCT 1 8 2001 Effective Date:

1 2001

Citation(s)						
	0	Groups Covered				
1902(a)(10)(A)	B.	Optional Coverage Other Than the Medically Needy (Continued)				
and 1920 of the Act	<u>X</u> 23.	Women who:				
	а.	have been screened for breast or cervical				
		calleer under the Centers for Discourse				
		and rievention Breast and Common Common				
		Daily Delection Program actability t				
		Lac A V UI Lie Pliblic Health Commission				
		accordance with the requirements of				
		orcast of cervical cancer including				
	*	cancerous condition of the breast or cervin				
	* × *					
	Ь.	are not otherwise covered under creditable				
		coverage, as defined in section 2701 ()				
		the Public Health Service Act;				
	с.	are not eligible for Medicaid under any				
		mandatory categorically needy eligibility				
1		group; and				
	d.	have not attained age 65.				
20B of the Act	24	88				
	24.	Women who are determined by a "qualified				
	entity" (as					
	Act related	to certain breast and cervical cancer patients.				
	The presumptive period begins on the day that the determination is made. The period ends on the date that the State makes a determination of its state makes					
	the State ms	ikes a determination of the date that				
	the State makes a determination with respect to the woman's eligibility for Medicaid, or if the woman does no apply for Medicaid (or a Medicaid and it)					
	apply for M	edicaid (or a Madianti or if the woman does not				
	made on her	edicaid (or a Medicaid application was not behalf) by the last i				
	eligibility un	which the determination of presumptive				
	last day.	is made, the presumptive period ends on that				
	j.					
lo. 01-006						

Revision:	HCFA-PM-91 August 1991		(BPD)		ATTACHMENT 2.2-A Page 24
	State: _		HAWAII		OKB NO.: 0938-
Agency*	Citation(s)		*	Groups Cove	red
	c.	<u>Opti</u>	onal Covera	ae of the Medica	11v Needy
42 CF1	R 435.301	This	plan inclu	des the medically	y needy.
		17	No.		
	1	127	Yes. Thi	s plan covers:	
			esources, w	en who, except fo ould be eligible XIX of the Act.	or income and/or as categorically needy
1902(e Act) of the	frt t p P	or and have eceive Medi he approved nds. These hey were pr ostpartum s eriod, begi	women continue egnant, for all pervices under the nning with the de	icaid and
1902(4 (C)(1) of the		1	ncome and/o	under age 18 who pr resources, wou on 1902(a)(10)(A)	ld be eligible
		4			

TN No. 91-21 Supersedes Approval Date 10/13/92	Effective Date 10/01/91	
TN No.	HCFA ID: 7983E	
Revision: HCFA-PM-9 AUGUST 199		ATTACHMENT 2.2-A Page 25
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State:	HAWAII	OMB NO.: 0938-
Agency* Citation(s)	Groups Covered
c	. Optional Cover	age of Medically Needy (Continued)
1902(e)(4) of the Act	October 1, as medicall Medicaid on is deemed t Medicaid on	ldren born on or after 1984 to a woman who is eligible y needy and is receiving the date of the child's birth. The child o have applied and been found eligible for the date of birth and remains eligible r so long as the woman remains eligible ld is a member of the woman's household.
42 CFR 435.308	desci	cially eligible individuals who are not ibed in section C.3. above and who are the age of 21 20 19 18 or under age 19 who are full-time. students in a secondary school or in the equivalent level of vocational or technical training
	eligi	nable classifications of financially ble individuals under the ages of 21, 20, r 18 as specified below:
	<u>x</u> (1)	Individuals for whom public agencies are assuming full or partial financial responsibility and who are:
	<u>×</u> (•) In foster homes (and are under the age of 21).
	<u> </u>) In private institutions (and are under the age of 21).

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TN No. <u>91-21</u> Supersedes TN No.	Approval Date	10/13/92	Effective Date 10/01/91
		-	HCFA TD. 7483F

Revision:	HCFA-PM-91-4 August 1991	(8 P	(C r	ATTACHMENT 2.2-A Page 25a
	State:	HAWAII		OMB NO.: 0938-
Agency*	Citation(s)	× .		Groups Covered
	C. 01	otional	Coveraç	e of Medically Needy (Continued)
	1		(c)	In addition to the group under b.(1)(a) and (b), individuals placed in foster homes or private institutions by private, nonprofit agencies (and are under the age of 21).
		<u></u>	f	ndividuals in adoptions subsidized in full or part by a public agency (who are inder the age of 21).
		<u> </u>	O	ndividuals in NFs (who are under the age 19). NF services are provided nder this plan.
		<u> </u>	1	n addition to the group under (b)(3), ndividuals in ICFs/MR (who are under the ge of <u>19</u> }.
		<u>_X</u>	1 	ndividuals receiving active treatment as npatients in psychiatric facilities or rograms (who are under the age of 19). Inpatient psychiatric services or individuals under age 21 are provided nder this plan.
		<u> </u>		ther defined groups (and ages), as pecified in Supplement 1 of TTACHMENT 2,2-A.

- 3

TN No. 91-21 Supersedes TN No. 90-1	Approval	Date	10/13/92	Effective Date 10/01/91
IN NO		•	•	HCFA ID: 7983E

Revision: HCFA-PM-91-4 (BPD) August 1991

ATTACHMENT 2.2-A Page 26 OMB No.: 0938-

State: <u>Hawaii</u>

Agency *	Citation(s)				Group Covered
		c.	Or	otiona	al Coverage of Medically Needy
				ontir	nued)
42 C.F.R. 435	.310			6.	Caretaker relatives
42 C.F.R. 435	.320 and 435.330		\boxtimes	7.	Aged individuals
42 C.F.R. 435.	322 and 435.330			8.	Blind individuals
42 C.F.R. 435.	324 and 435.330			9.	Disabled individuals
42 C.F.R. 435.	326			10.	Individuals who would be ineligible if they were not enrolled in an HMO. Categorically needy individuals are covered under 42 C.F.R. 212 and the same rules apply to medically needy individuals.
				11.	Blind and disabled individuals who:
12 C.F.R. 435.3	326				a. Meet all current requirements for Medicaid eligibility except the blindness or disability criteria;
					b. Were eligible as medically needy in December 1973 as blind or disabled; and
					c. For each consecutive month after December 1973 continue to meet the December 1973 eligibility criteria.

TN No.	13-004b					
Supersedes TN No.	91-21	Approval	Date:	09/30/2013	Effective Date:	01/01/2014

ATTACHMENT 2.2-A. Page 27

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory:

HAWAII

REQUIREMENTS RELATING TO DETERMINING ELIGIBILITY FOR MEDICARE PRESCRIPTION DRUG LOW-INCOME SUBSIDIES

Agency	Citation(s)	Groups Covered
1935(a) and 42 CFR 42 and 423.9		The agency provides for making Medicare prescription drug Low Income Subsidy determinations under Section 1935(a) of the Social Security Act.
		 The agency makes determinations of eligibility for premium and cost-sharing subsidies under and in accordance with section 1860D-14 of the Social Security Act;
		 The agency provides for informing the Secretary of such determinations in cases in which such eligibility is established or redetermined;
		 The agency provides for screening of individuals for Medicare cost-sharing described in Section 1905(p)(3) of the Act and offering enrollment to eligible individuals under the State plan or under a waiver of the State plan.

Approval Date: SEP 0 2 2005Effective Date:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: <u>Hawaii</u>

REASONABLE CLASSIFICATION OF INDIVIDUALS UNDER THE AGE OF 21, 20, 19 AND 18

Other classification of financially eligible children: (continue)

 e. 2101(f)-Like Children: Children under age 19 years who were enrolled in Medicaid on December 31, 2013 and would otherwise become ineligible for Medicaid at their first determination using Modified Adjusted Gross Income (MAGI) based methodologies solely due to the loss of income disregards will remain Medicaid eligible until their next redetermination using MAGI methodologies. (42 C.F.R. 435.222)

TN No.	13-011				
Supersedes		Approval Date:	03/13/2014	Effective Date:	12/31/2013
TN NO.	NEW	2	1		

Revision: HCFA-PM-87-4 **MARCH 1987**

SUPPLEMENT 2 TO ATTACHMENT 2.2-A Page 1 OMB No.: 0938-0193

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

REALEXEX State: HAWATT

A. DEFINITION OF BLINDNESS IN TERMS OF OPHTHALMIC MEASUREMENT

(BERC)

- Individual is medically certified to have a central visual ---
- -acuity of 20/200, or less, in the better eye with correcting
- -lenses or have a field subbends an angular-distance no--

- greater than twenty degrees - (turnel- vision) ----

Not applicable.

*Agency that determines eligibility for coverage.

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Approval Date NOV 1 7 1987

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TN No. 87-11 Supersedes TH No. A 0

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Effective Date

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HCFA ID: 2002P/0021P

Revision: HCFA-PM-91-4 (BPD) AUGUST 1991 SUPPLEMENT 3 TO ATTACHMENT 2.2-A Page 1 OMB NO.: 0938-

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: HAWAII

Method for Determining Cost Effectiveness of Caring for Certain Disabled Children At Home

Not Applicable

	Approval Date	10/13/92	Effective Date 10/01/91
TN NO.			HCFA ID: 7983E

Revision: HCPA-PH-92 -1 (HB) FEBRUARY 1992

ATTACHMENT 2.6-A

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: HAWAII

 ELIGIBILITY	CONDITIONS .	111	BRAILTBRURNE
	AAMAY PANA VIA VIA		RECULRENSETS

Citation(s)

Condition or Requirement

A. General Conditions of Bligibility

Each individual covered under the plan:

42 CFR Part 435, Subpart G

42 CFR Part 435, Subpart F

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I.

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• 1 3 1902(1) of the Act

1902(m) of the Act

- 1. Is financially sligible (using the methods and standards described in Parts B and C of this Attachment) to receive services.
- 2. Meets the applicable non-financial eligibility conditions.
- a. For the categorically needy:
 - (i) Except as specified under items A.2.a.(i. and (iii) below, for APDC-related individuals, meets the non-financial eligibility conditions of the APDC program.
 - (ii) For SSI-related individuals, meets the non-financial criteria of the SSI program or more restrictive SSI-related. categorically needy criteria.
 - (iii) For financially eligible pregnant women, infants or children covered under sections 1902(a)(10)(A)(i)(IV), 1902(a)(10)(A)(i)(VI), 1902(a)(10)(A)(i)(VII), and 1902(a)(10)(A)(ii)(IX) of the Act, meets the non-financial criteria of section 1902(1) of the Act.
 - (iv) For financially eligible aged and disabled individuals covered under secti 1902(a)(10)(A)(ii)(X) of the Act, meets the non-financial criteria of section 1902(m) of the Act.

Revision: CMS-PM-09 July 2009

ATTACHMENT 2.6-A Page 2 OMB No.: 0938-

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT State: <u>Hawaii</u>

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation	Condition or Requirement
	b. For the medically needy, meets the non- financial eligibility condition of 42 CFR Par 435.
1905 (p) of the Act	 c. For financially eligible qualified Medicare beneficiaries covered under section 1902 (a) (10) (E) (i) of the Act, meets the non-financial criteria of section 1905 (p) of the Act.
1905 (s) of the Act	d. For financially eligible qualified disabled and working individuals covered under section 1902 (a) (10) (E) (ii) of the Act, meets the non-financial criteria of section 1905(s).
42 CFR 435.406	3. Is residing in the United States and
	a. Is a citizen or national of the United States;
	b. Is a qualified alien (QA) as defined in section 431 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) as amended, and the QA's eligibility is required by section 402 (b) of PRWORA as amended, and is not prohibited by section 403 of PRWORA as amended;
	c. Is a qualified alien subject to the 5-year bar as described in section 403 of PRWORA, so that eligibility is limited to treatment of an emergency medical condition defined in section 401 of PRWORA:

Revision: CMS-PM-09 July 2009

ATTACHMENT 2.6-A Page 3 OMB No.: 0938-

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT State: <u>Hawaii</u>

Citation	Condition or Requirement
	d. Is a non-qualified alien, so that eligibility is limited to treatment of an emergency medical condition as defined in section 401 of PRWORA;
	 e. Is a qualified alien (QA) whose eligibility is authorized under section 402 (b) of PRWORA as amended, and is not prohibited by section 403 of PRWORA as amended. X State covers all authorized QAs. State does not cover authorized QAs.
	 f. State elects CHIPRA option to provide full Medicaid coverage to otherwise eligible aliens lawfully residing in the United States; such aliens consist of qualified aliens subject to the 5-year bar, aliens described in 8 CFR 103.12 (a)(4), and legal non-immigrants whose admission to the U.S. is not conditioned on having a permanent residence in a foreign country (such non- immigrants include citizens of the Compact of Free Association States who are considered permanent non-immigrant but does not include visitors for business or pleasure or student): X Elected for pregnant women. X Elected for children under age 19
2 CFR 435.406 1902 (b) f the Act	4. Is a resident of the State, regardless whether or not the individual maintains the residence permanently or maintains it at a fixed address.
	State has interstate residency agreement with the following States:
	State has open agreement(s).
12	Not applicable; no residency requirement.

ELIGIBILITY CONDITIONS AND REQUIREMENTS

TN No: <u>09-003</u> Supersedes TN No. <u>91-21</u> Approval Date: JUL 3 1 2009

Effective Date: April 1, 2009

Revision:

HCFA-PM-91-1 (MB) February 1992

ATTACHMENT 2.6-A Page 3a OMB No.: 0938

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: <u>HAWAII</u>

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
42 C.F.R. 435.1008	5. a. Is not an inmate of a public institution. Public institution do not include medical institutions, nursing facilities and intermediate care facilities for the mentally retarded, or publicly operated community residences that serve no more than 16 residents, or certain child care institutions.
42 C.F.R. 435.1008 1905(a) of the Act	 b. Is not a patient under age 65 in an institution for mental diseases except as an inpatient under age 22 receiving active treatment in an accredited psychiatric facility or program.
	Not applicable with respect to individuals under age 22 in psychiatric facilities or programs Such services are not provided under the plan.
2 C.F.R. 433.145 <u>and</u> 435.604 912 of the Act	6. Is required, as a condition of eligibility to assign his or her own rights, or the rights of any other person who is eligible for Medicaid and on whose behalf the individual has legal authority to execute an assignment to medical support and payment for medical care from any third party. (Medical support is defined as support specified as being for medical car by a court or administrative order.)
	Assignment of rights is automatic because of State law.
2 C.F.R. 435.910	7. Is required, as a condition of eligibility, to furnish his/her social security account number (or numbers, if he/she has more than one number). Exception, aliens seeking medical assistance for the treatment of an emergency medical condition under Section

TN No.	13-004b		<u> </u>		
Supersedes		Approval Date:	09/30/2013	Effective Date:	01/01/2014
TN No.	91-21		24		

	HCFA-PM-91-8 October 1991	(BPE))	ATTACHMENT 2.6-4 Page 3c
24 	Stat	e:	HAWAII	OMB NO.: 0938 -
Citation	L		Condition or R	equirement
<u>Citation:</u> 1906 of the A	10. Act	Is required cost-effect to the indiv except for own behalf	vidual. Enrollment	ment in an employer-based an, if such plan is available is a condition of eligibility is unable to enroll on his/her t to enroll a child does not
U.S. Supreme Court case New York State Department of Social Services v. Dublino,413 U. S. 405 (1973	9)	the eligibility The state ag sharing (exc individuals for Medicard does not pay insurance (ex- persons cover	ty criteria for any o press to pay any app cept those applicable required to apply for is a condition of e the Medicare pren accent those applicable	ge under Medicare Parts A, he individual would meet r all of those programs. blicable premiums and cost- e under Part D) for r Medicare. Application bligibility unless the state niums, deductibles or co- ble under Part D) for d eligibility group under g.

Approval Date: MOV 1 8 2005 Effective Date:

01/01/06

E	Revision:	HCFA-PM-9 December 19	-97-2 ATTACHMENT 2.6-A 1997 Page 4
	Stat	e:HAWAII	
	Citation		Condition or Requirement
•	B.	Posteligibility Indivi	ty Treatment of Institutionalized viduals' Incomes
		1. TI po	The following items are not considered in the posteligibility process:
	1902(o) of the Act	a .	a. SSI and SSP benefits paid under §1611(e)(1)(E) and (G) of the Act to individuals who receive care in a hospital, nursing home, SNF, or ICF.
	Bondi v Sullivan (SSI)	Ь.	Austrian Reparation Payments (pension (reparation) payments made under §500 - 506 of the Austrian General Social Insurance Act). Applies only if State follows SSI program rules with respect to the payments.
0 c	1902(r)(1) of the Act	C.	. German Reparations Payments (reparation payments made by the Federal Republic of Germany).
	105/206 of P. L. 100-383	đ.	Japanese and Aleutian Restitution Payments.
	1. (a) of P.L. 103-286	6.	Netherlands Reparation Payments based on Nazi, but not Japanese, persecution (during World War II).
	10405 of P.L. 101-239	f.	Payments from the Agent Orange Settlement Fund or any other fund established pursuant to the settlement in the In re Agent Orange product liability litigation, M.D.L. No. 381 (E.D.N.Y.)
•	6(h)(2) of P.L. 101-426	8-	Radiation Exposure Compensation.
•	12005 of P. L. 103-66	h.	VA pensions limited to \$90 per month under 38 U.S.C. 5503.
	TN No. <u>98-00</u> Supersedes	<u>)3</u> Ap	pproval Date 12/11/98 Effective Date 10/198
	TN No. 91-21		

Revision: CMS-PM 97-2 May 2002

HAWAII

Т, **к**

State:

ATTACHMENT 2.6-A Page 4a OMB No.:0938-0673

Citation	Condition or Requirement
1924 of the Act	2 The following monthly emounts for several to a
435.725	2. The following monthly amounts for personal needs are deducted from total monthly is some in the second s
435.733	deducted from total monthly income in the application
435.832	of an institutionalized individual's or couple's
433.032	income to the cost of institutionalized care:
	Personal Needs Allowance (PNA) of not less than \$50
	tor individuals and \$100 for Couples for all
	Institutionalized Persons.
	a. Aged, blind, disabled:
	Individuals <u>\$ 50.00</u>
	Couples \$100.00
	For the following persons with greater need:
	Supplement 12a to Attachment 2.6-A describes the
	greater need; describes the basis or formula for
	determining the deductible amount when a specific
	amount is not listed above; lists the criteria to
	be met: and where expression identifies the
	be met; and, where appropriate, identifies the
	organizational unit which determines that a criterion is met
	b. AFDC related:
	Children \$ 50.00
	Adults \$ 50.00
	For the following persons with greater need:
	Supplement 12a to Attachment 2.6-A describes the
	greater need; describes the basis or formula for
	determining the deductible amount when a specific
	amount is not listed above; lists the criteria to be met;
	and, where appropriate, identifies the organizational
	unit which determines that a criterion is met.
	c. Individual under age 21 covered in the plan as
	specified in Item B. 7. of <u>Attachment 2.2 -A</u> .
	\$_N/A
No. 07-006	
	Approval Date: DEC 1 2 2007 Effective Date: 07/01/07

0 r	Revision: HCI Dec. State: <u>HA</u>	FA-PM-97-2 ember 1997	ATTACHMENT 2.6-A Page 4b OMB No.:0938-0673
	Citation	Con	dition or Requirement
		For the following p	ersons with greater need:
		determining the ded amount is not listed be met; and, where	ttachment 2.6-A describes the bes the basis or formula for uctible amount when a specific above; lists the criteria to appropriate, identifies the which determines that a
	1924 of the Act	3. In addition to the a amounts are dedu institutionalized individual	unce the remaining income of an vidual with a community spouse:
0 с		a. The monthly inc calculated using t which the mainter spouse's income. the maximum ore	come allowance for the community spouse, the formula in $\$1924(d)(2)$, is the amount by nance needs standard exceeds the community The maintenance needs standard cannot exceed scribed in $\$1924(d)(3)(C)$. The maintenance
			(91924(d)(3)(B) of the
*		than the applicable	y level component is percentage greater percentage, equal to ficial poverty level timum maintenance needs standard).
		The mainter community spouses permitted by §1924	nance needs standard for all is set at the maximum $M(d)(3)(C)$.
		spouse's monthly i exceptional maintena	applicable, the State will set the community income allowance at the amount by which ince needs, established at a fair hearing, exceed use's income, or at the amount of any court-
	TN No. 98-003		
	Supersedes TN No.	Approval Date 12.	198 Effective Date 10 11 98

TN No._

State:		Revision:	HCFA-PM-97-2 December 1997	ATTACHMENT 2.6-A Page 4c
In determining any excess shelter allowance, utility expenses are calculated using: 		State:	HAWAII	OMB No.:0938-0673
 the standard utility allowance under §5(e) of the Food Stamp Act of 1977; or the actual unreimbursable amount of the community spouse's utility expenses less any portion of such amount included in condominium or cooperative charges. The monthly income allowance for other dependent family members living with the community spouse is: <u>x</u> one-third of the amount by which the poverty level component (calculated under § 1924(d)(3)(A)(i) of the Act, using the applicable percentage specified in § 1924(d)(3)(B)) exceeds the dependent family member's monthly income. <u>a</u> greater amounted calculated as follows: The following definition is used in lies of the definition provided by the Secretary to determine the definition provided by the Secretary to determine the definition provided by the Secretary to determine the definition are not subject to payments by a third party: (i) Medicaid, Medicare, and other health insurance premiums, deductibles, or coinsurance charges, or copayments. (ii) Necessary medical or remedial care recognized under State law but not covered under the State plan. (Reasonable limits on amounts are described in you part to determine the premiums, deductibles, or coinsurance charges, or copayments. 	_	Citation		Condition or Requirement
 9.2(6) of the Pood Stamp Act of 1977; or the actual unreimbursable amount of the community spouse's utility expenses less any portion of such amount included in condominium or cooperative charges. b. The monthly income allowance for other dependent family members living with the community spouse is: <u>A</u> one-third of the amount by which the poverty level component (calculated under §1924(d)(3)(A)(i) of the Act, using the applicable percentage specified in §1924(d)(3)(B)) enceeds the dependent family member's monthly income. <u>B</u> greater amounted calculated as follows: The following definition is used in lieu of the dependency of family members under §1924(d)(1): c. Amounts for health care expenses described below that are incurred by and for the institutionalized individual and are not subject to payments by a third party: (i) Medicaid, Medicare, and other health insurance premiums, deductibles, or coinsurance charges, or copsyments. (ii) Necessary medical or remedial care recognized under the State plan. (Reasonable limits on amounts are described in Supplement 3 to not subject to payments are on amounts are described in the superiments of a mounts are based by a mount or covered under the State plan. (Reasonable limits on amounts are described in Supplement 3 to not subject to payments are not subject to payment a to not subject to payment at the previous of the state plan. (Reasonable limits on amounts are described in Supplement 3 to not payments are previous planet. 	-		In determining utility expenses	any excess shelter allowance, are calculated using:
 Community spouse's utility expenses less any portion of such amount included in condominium or cooperative charges. b. The monthly income allowance for other dependent family members living with the community spouse is: 	_	,	the stand §5(e) of	ard utility allowance under the Food Stamp Act of 1977; or
 			any porti	by spouse's utility expenses less
 prover § 1924(d)(3)(A)(i) of the Act, using the applicable percentage specified in §1924(d)(3)(B)) exceeds the dependent family member's monthly income. <u>a greater amounted calculated as follows:</u> The following definition is used in lieu of the definition provided by the Secretary to determine the dependency of family members under §1924(d)(1): C. Amounts for health care expenses described below that are incurred by and for the institutionalized individual and are not subject to payments by a third party: (i) Medicaid, Medicare, and other health insurance premiums, deductibles, or coinsurance charges, or copayments. (ii) Necessary medical or remedial care recognized under State law but not covered under the State plan. (Reasonable limits on amounts are described plan. (Reasonable limits on amounts are described plan. Supplement 3 to another the state plan. (Reasonable limits on amounts are described plan. Supplement 3 to another the state plan. (Reasonable limits on amounts are described plan. Supplement 3 to another the state plan. (Reasonable limits on amounts are described plan. Supplement 3 to another the state plan. 			b. The monthly inc family members	ome allowance for other dependent living with the community spouse is:
 come appicable percentage specified in §1924 (d)(3)(B)) exceeds the dependent family member's monthly income. a greater amounted calculated as follows: The following definition is used in lieu of the definition provided by the Secretary to determine the dependency of family members under §1924 (d)(1): c. Amounts for health care expenses described below that are incurred by and for the institutionalized individual and are not subject to payments by a third party: (i) Medicaid, Medicare, and other health insurance premiums, deductibles, or coinsurance charges, or copsyments. (ii) Necessary medical or remedial care recognized under State plan. (Reasonable limits on amounts are described in Supplement 3 to be an of the supplement of the state plan. (Reasonable limits on amounts are described in Supplement 3 to be an of the supplement of the supplement of the state plan. (Reasonable limits on amounts are described in Supplement 3 to be an of the supplement of the supercenter of the supplement of the supercenter of the supplement of the supercenter of the supplement of the supercenter of the s			under S1	24(d) 3) (A) (i) of the Art
 The following definition is used in lieu of the definition provided by the Secretary to determine the dependency of family members under §1924 (d)(1): C. Amounts for health care expenses described below that are incurred by and for the institutionalized individual and are not subject to payments by a third party: (i) Medicaid, Medicare, and other health insurance premiums, deductibles, or coinsurance charges, or copsyments. (ii) Necessary medical or remedial care recognized under State law but not covered under the State plan. (Reasonable limits on amounts are described in Supplement 3 to 			adharmen	in §1924 (d)(3)(B)) exceeds the family member's monthly
 C. Amounts for health care expenses described below that are incurred by and for the institutionalized individual and are not subject to payments by a third party: (i) Medicaid, Medicare, and other health insurance premiums, deductibles, or coinsurance charges, or copayments. (ii) Necessary medical or remedial care recognized under State law but not covered under the State plan. (Reasonable limits on amounts are described in Supplement 3 to 			& grea	ter amounted calculated as follows:
 (i) Medicaid, Medicare, and other health insurance premiums, deductibles, or coinsurance charges, or copsyments. (ii) Necessary medical or remedial care recognized under State law but not covered under the State plan. (Reasonable limits on amounts are described in Supplement 3 to 		·	CELLILLON Drovide	d by the Secretary to determine the
 (ii) Necessary medical or remedial care recognized under State law but not covered under the State plan. (Reasonable limits on amounts are described in Supplement 3 to 		•		V and for the institutionalized
under the State plan. (Reasonable limits on amounts are described in Supplement 3 to	·		premiums,	ieductibles, or coinsurance charges
	15		under the State amounts are d	der State law but not covered e plan. (Reasonable limits on escribed in Supplement 3 to
	-			

TN No.__

Revision:	a a water fully to the	97-2 1997
	December	

State: HAWAII

ATTACHMENT 2.6-A Page 5 OMB No.:0938-0673

Citation	Condition of Real
435.725	Condition or Requirement
435.733 435.832	4. In addition to any amounts deductible under the items above, the following monthly amounts are deducted from the remaining monthly income of an institutionalized individual or an institutionalized counter
	individual or an institutionalized couple:
	a. An amount for the maintenance needs of each member of a family living in the institutionalized individual's home with no community spouse living in the home. The amount must be based on a reasonable assessment of need but must not exceed the higher of the:
	o AFDC level; or o Medically needy level:
· *	
	(Check one)
	- AFDC levels in Supplement 1
	X Medically needy level in Supplement 1 - Other: S
	 b. Amounts for health care expenses described below that have not been deducted under 3.c. above (i.e., for an institutionalized individual with a community spouse), are incurred by and for the institutionalized individual with a or institutionalized couple, and are not subject to the payment by a third party: (I) Medicaid. Medicare and action is the institution of the payment by a third party:
	(I) Medicaid, Medicare, and other health insurance premiums, deductibles, or coinsurance charges, or copayments.
126 206	(ii) Necessary medical or remedial care recognized under State law but not covered under the State plan. (Reasonable limits on amount are described in Supplement 3 to <u>ATTACHMENT 2.6-A.</u>)
35.725 35.733 35.832	 At the option of the State, as specified below, the following is deducted from any remaining monthly income of an institutionalized individual or an institutionalized couple:
	A monthly amount for the maintenance of the home of the individual or couple for not longer than 6 months if a physician has certified that the individual, or one member of the institutionalized couple, is likely to return to the home within that period:
	_ <u>X_</u> No.
	Yes (the applicable amount is shown on page 5a.)
N No. 98-003	Approval Date 12/11/98 Effective Date 11/11/6

Revision:	HCFA-PM-97-2 December 1997
	December 1997

ATTACHMENT 2.6-A Page 5a OMB No.:0938-0673

Effective Date 101, 198

State: HAWAII

Citation	Condition or Requirement
	Amount for maintenance of home is: S
	Amount for maintenance of home is the actual maintenance costs not to exceed S
	Amount for maintenance of home is deductible when countable income is determined under §1924(d)(1) of the Act only if the individuals' home and the community spouse's home are different.
	Amount for maintenance of home is not deductible when countable income is determined under $\S1924$ (d)(1) of the Act.

Approval Date 12/11/88

TN No. <u>98-003</u> Supersedes TN No. <u>94-002</u>

AT1. dMENT 2.6-A Page 5b

Citation

Condition or Requirement

"Dependency" means the status of a child, parent, or sibling who resides with the community spouse, and who may be claimed as a legal tax dependent of either spouse under the Internal Revenue Code.

TN No. <u>89-10</u> Supercedes TN No.

Approval Date 09/13/90

Effective Date 10/01/89

State: <u>Hawaii</u>

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
42 C.F.R. 435.601,435.631, 435.831	C. Financial Eligibility
	For individuals who are AFDC or SSI recipients, the income and resource levels and methods for determining countable income and resources of the AFDC and SSI program apply, unless the plan provides for more restrictive levels and methods than SSI for SSI recipients under section 1902(f) of the Act, or more liberal methods under section 1902(r)(2) of the Act, as specified below.
	For individuals who are not AFDC or SSI recipients a non-section 1902(f) State and those who are deemed to be cash assistance recipients, the financial eligibility requirements specified in this section apply
	Supplement 1 to Attachment 2.6-A specifies the income levels for mandatory and optional categorically needy groups of individuals, including individuals with incomes related t the Federal income poverty level - pregnant women and infants or children covered under
	sections 1902(a)(10)(A)(i)(IV), 1902(a)(10)(A)(i)(VI), 1902(a)(10)(A)(i)(VII), and 1902(a)(10)(A)(ii)(IX) of the Act and aged and disabled individuals covered under section 1902(a)(10)(A)(ii)(X) of the Act -
	and for mandatory groups of qualified Medicare beneficiaries covered under section 1902(a)(10)(E)(i) of the Act.

TN NO.	13-010		<u> </u>		
Supersedes		Approval Date:	02/12/2014	Effective Date:	10/01/2013
TN NO.	92-15		N		

13-010

92-15

TN No.

Supersedes TN No.

State: <u>Hawaii</u>

Citation(s)		Condition or Requirement
		Supplement 2 to ATTACHMENT 2.6-A specifies the resource levels for mandatory and optional categorically needy poverty level related groups, and for medically needy groups.
		Supplement 7 to ATTACHMENT 2.6-A specifies the income levels for categorically needy aged, blind and disabled persons who are covered under requirements more restrictive than SSI.
		Supplement 4 to ATTACHMENT 2.6-A specifies the methods for determining income eligibility used by states that have more restrictive methods than SSI, permitted under section 1902(f) of the Act.
		Supplement 5 to ATTACHMENT 2.6-A specifies the methods for determining resource eligibility used by States that have more restrictive methods than SSI, permitted under section 1902(f) of the Act.
		Supplement 8a to ATTACHMENT 2.6-A specifies the methods for determining income eligibility used by States are more liberal than the methods of the cash assistance programs, permitted under section 1902(r)(2) of the Act.
	· 🛛	Supplement 8b to ATTACHMENT 2.6-A specifies the methods for determining resource eligibility used by States are more liberal than the methods of the cash assistance programs, permitted under section 1902(r)(2) of the Act.
		Supplement 14 to ATTACHMENT 2.6-A specifies income levels used by States for determining resource eligibility of Tuberculosis-infected individuals whose eligibility is determined under §1902(z)(1) of the Act.

Approval Date: 02/12/2014 Effective Date: 10/01/2013

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Revision: HCFA-PM-92-1 (MB) FEBRUARY 1992

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ATTACHMENT 2.6-J Page 7

STATE PLAN UNDER	TITLE	XIX	07	THE	SOCIAL	SECURITY	ACT	
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Citatio	n(e)			ITIONS AND REQUIREMENTS
			~~~	dition or Requirement
1902(r)(2) of the Act		1.		of Determining Income
				C-related individuals (except for poverty el related pregnant women, infants, and Idren).
4 V			(1)	
				X (a) The methods under the State's approved AFDC plan only; or
		•		(b) The methods under the State's approved AFDC plan and/or any liberal methods described in Supplement 8a to ATTACHMENT 2
•			(2)	
1902(e)(6) the Act			(3)	Agency continues to treat women eligible under the provisions of section 1902(a)(10) of the Act as eligible, with regard to any changes in income of the family of which she is a member, for the 60-day period after her pregnancy ends a any remaining days in the month in which 60th day falls.

## Revision: HCFA-PH-92 -1 FEBRUARY 1992 (MB)

#### ATTACHDENT 2.6-A Page 74

# STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

## State: HAWAII

Citation(s)	BILITY CONDITIONS AND REQUIREMENTS Condition or Requirement
42 CFR 435.721 435.831, and 1902(m)(1)(B)(m)(4) and 1902(r)(2) of the Act	b. Aged individuals. In determining countable income for aged individuals, including aged individuals with incomes up to the Federal poverty level described in section 1902(m)(1) of the Act, the following methods are used:
	X The methods of the SSI program only.

- The methods of the SSI program and/or any more liberal methods described in Suppleme Ba to ATTACHMENT 2.6-A.



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TN No. 92-15			
Supersedes TN No. 91-21	Approval	Date	10/29/92

Revision:	HCFA-PM-91- August 1991	4 (BPD)	ATTACHMENT 2.6-A Page 8
	State:	HAWAII	OMB No.: 0938-
Citati	on		Condition or Requirement
		supplem than SS 1902(f) <u>to ATTA</u>	dividuals other than optional State ment recipients, more restrictive methods SI, applied under the provisions of section ) of the Act, as specified in <u>Supplement 4</u> <u>ACHMENT 2.6-A</u> ; and any more liberal methods bed in <u>Supplement 8a to ATTACHMENT 2.6-A</u> .
	1	For ins	stitutional couples, the methods specified section 1611(e)(5) of the Act.
	. 4	∠_/ For opt \$435.23	tional State supplement recipients under 30, income methods more liberal than SSI, a ied in <u>Supplement 4 to ATTACHMENT 2.6-A</u> .
	L	/X7 For opt section	tional State supplement recipients in n 1902(f) States and SSI criteria States t section 1616 or 1634 agreements
		<u>x</u> s	SSI methods.malga
		t.	SSI methods and/or any more liberal methods than SSI described in <u>Supplement Sa to</u> <u>ATTACHMENT 2.6-A</u> .
			Acthods more restrictive and/or more liberathan SSI. More restrictive methods are described in <u>Supplement 4 to ATTACHMENT</u> 1.6-A and more liberal methods are describe in <u>Supplement 8 to ATTACHMENT 2.6-A</u> .
		the age	ermining relative financial responsibility, ancy considers only the income of spouses in the same household as available to
	1-21		
Supersedes TN No		coval Date 10	0/13/92Effective Date0/01/91 HCFA ID: 7985E

Revision: HCFA-PM-91-4 (BPD) AUGUST 1991

ATTACHMENT 2.6-A Page 9 OMB No.: 0938-

State: HAWAII

Citation		Condition or Requirement
42 CFR 435.721 435.831 1902(m)(1)(B), (m)(4), and	and c.	Blind individuals. In determining countable income for blind individuals, the following methods are used:
1902(r)(2) of the Act		X The methods of the SSI program. only a
•		SSI methods and/or any more liberal methods described in <u>Supplement Sa to ATTACHMENT</u> 2.6-A.
	•	X For individuals other than optional State supplement recipients, more restrictive methods than SSI, applied under the provision of section 1902(f) of the Act, as specified i <u>Supplement 4 to ATTACHMENT 2.6-A</u> , and any more liberal methods described in <u>Supplement 8a to</u> ATTACHMENT 2.6-A.
	\$ ¹¹	For institutional couples, the methods specified under section 1611(e)(5) of the Act.
	ж. П	For optional State supplement recipients under \$435.230, income methods more liberal than SSI as specified in <u>Supplement 4 to ATTACHMENT</u> 2.6-A.
	-	XFor optional State supplement recipients in section 1902(f) States and SSI criteria States without section 1616 or 1634 agreements
		X_ SSI methods. salar
		SSI methods and/or any more liberal methods than SSI described in <u>Supplement fa to</u> ATTACHMENT 2.6-A.
		X Methods more restrictive and/ or more liberal than SSI. More restrictive methods are described in <u>Supplement 4 to ATTACHMENT</u> 2.6-A and more liberal methods are described in <u>Supplement Sa to ATTACHMENT 2.6-A</u> .

HCFA ID: 7985E

	991 (BPD) HAWAII	ATTACHMENT 2.6-A Page 10 OHB No.: 0938-
Citation	Condit	ion or Requirement
42 CFR 435.721, and 435.831 1902(m)(1)(B), (m)(4), and 1902(r)(2) of the Act	In determining rela considers only the same household as a of parents as evail parents until the c d. Disabled individuals countable income of individuals, includ with incomes up to level described in a the Act the followin X. The methods of SSI methods an described in S 2.6-A. For institution specified under SSI, as specifi 2.6-A. X. For individuals supplement recip individuals desc the Act, as a splied under the of the Act, as a	ative responsibility, the agency income of spouses living in the available to spouses and the incom lable to children living with children become 21. f. In determining disabled ing individuals the Federal powerty

TN No. 91-21 Supersedes TN No.

Approvel Date 10/13/92 -

Effective Date 10/01/91

HCFA ID: 79855

Revision:	HCFA-PM-91- AUGUST 1991	(BPD)	ATTACHMENT 2.5-A
	State:	HAWAII	Page 11 OMB No.: 0938-
Citati	on	Condit	ion or Requirement
		X For optional section 1902 without sect	State supplement recipients in (f) States and SSI criteria States ion 1616 or 1634 agreements
		<u> </u>	is and/or any more liberal methods
	:	ATTACHMENT X Methods mo than SSI, individual of the Act described 2.5-A and 1	2.5-A. Te restrictive and/or more liberal except for aged and disabled s described in section 1902(m)(1) . More restrictive methods are in <u>Supplement 4 to ATTACHMENT</u>
		in <u>Supplem</u> In determining relat agency considers on the same household a income of Derest	Ent Sa to ATTACHMENT 2.6-A. tive financial responsibility, the ly the income of spouses living in a vailable to spouses and the available to children living the children become 21.

TN No. 91-21		
	Approval Date 10/13/97	Effective Date 10/01/91
		HCFA ID: 79858

#### Revision: HCFA-PM-92-1 FEBRUARY 1992

(MB)

#### ATTACHMENT 2.6-A Page 12

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

#### States HAWAII

## BLIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)

Condition or Requirement

(2) In determining relative financial responsibility, the agency considers only the income of spouses living in the same household as available to spouses and the has he thanks and a same income of parents as available to children living with parents until the children become 21. 1902(e)(6) of The agency continues to treat women (3) the Act eligible under the provisions of sections 1902(a)(10) of the Act as eligible, withou regard to any changes in income of the family of which she is a member, for the 60-day period after her pregnancy ends and any remaining days in the month in which t 60th day falls. 1905(p)(1), Qualified Medicare beneficiaries. In determining countable income for qualified f. 1902(m)(4), and 1902(r)(2) of Medicare beneficiaries covered under section the Act 1902(a)(10)(E)(1) of the Act, the following methods are used: X The methods of the SSI program only. SSI methods and/or any more liberal method than SSI described in Supplement Sa to ATTACHMENT 2.6-A. For institutional couples, the methods

specified under section 1611(e)(5) of the Act.

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•	MB )	ATTACHMENT 2.6-A Page 12a
F	AWAIJ	
		Condition or Requirement
	in tit "tr the end the	an individual receives a title II benefit, an ounts attributable to the most recent increas the monthly insurance benefit as a result of le II COLA is not counted as income during ansition period" beginning with January, whe title II benefit for December is received, and ing with the last day of the month following month of publication of the revised annual eral poverty level.
	day	individuals with title II income, the revised erty levels are not effective until the first of the month following the end of the nsition period.
·		individuals not receiving title II income, the ised poverty levels are effective no later than date of publication.
g.	(1)	Qualified disabled and working individuals.
		In determining countable income for qualified disabled and working individuals covered under 1902(a)(10)(E)(ii) of the Act, the methods of the SSI program are used.
	(2)	Specified low-income Medicare beneficiaries.
		In determining countable income for specified low-income Medicare beneficiaries covered under 1902(a)(10)(E)(iii) of the Act, the
		in tit "tr the end the Fed For pov day trai For rev: the g. (1)

No. 93-03				TN
No. <u>93-03</u> Supersedes TN No. 92-15	Approval Date	5/3/93	Effective Date	1/1/93

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Revision:	HCFA-PM-91-4 August 1991	(BPD)	ATTACHMENT 2.6-A Page 13 OMB No.: 0938-		
	State:	HAWAII			
Citati	ол	Condition or Requirement			
1902(k) of Act		fedicaid Quali			
		iescribed in s mount from th individual who established th trustee(s) is the individual individual, wh made. This pr initial trust solely for the	a Medicaid qualifying trust ection 1902(k)(2) of the Act, the e trust that is deemed available to the established the trust (or whose spouse to trust) is the maximum amount that the permitted under the trust to distribute to the ther or not the distribution is actually covision does not apply to any trust or decree established before April 7, 1986, a benefit of a mentally retarded individua the an intermediate care facility for the rded.		
	4	describe determin Suppleme	ncy does not count the funds in a trust as ad above in any instance where the State hes that it would work an undue hardship. ant 10 of ATTACHMENT 2.5-A specifies what ites an undue hardship.		
1902(a)(10 of the Act		Medically need family size.	iy income levels (WNILS) are based on		
		all covered mo chooses more	to ATTACHMENT 2.6-A specifies the MNILs fo adically needy groups. If the agency restrictive levels under section 1902(f) o lement 1 so indicates.		

TN No. 91-21 Supersedes TN No. 88-18	Approval Date	Effective	Dete	
TN NO		•	HCFA ID:	7985E

Revision:	HCFA-PM-91-4 AUGUST 1991	(BPD) Hawaii	ATTACHMENT 2.6-A Page 14 OMB No.: 0938-	a Tari
Citati	State:	1411111	Condition or Requirement	

42 CFR 435.732,<br/>435.8314. Handling of Excess Income - Spend-down for the<br/>Medically Needy in All States and the Categorically<br/>Needy in 1902(f) States Only

#### a. Medically Needy

- (1) Income in excess of the MNIL is considered as available for payment of medical care and services. The Medicaid agency measures available income for periods of mixtures <u>one</u> ex <u>month(S)</u> (not to exceed 6 months) to determine the amount of excess countable income applicable to the cost of medical care and services.
- (2) If countable income exceeds the MNIL standard, the agency deducts the following incurred expenses in the following order:
  - (a) Health insurance premiums, deductibles and coinsurance charges.
  - (b) Expenses for necessary medical and remedial care not included in the plan.
  - (c) Expenses for necessary medical and remedial care included in the plan.
    - Reasonable limits on amounts of expenses deducted from income under a.(2)(a) and (b) above are listed below.

1902(a)(17) of the Act

1

Incurred expenses that are subject to payment by a third party are not deducted unless the expenses are subject to payment by a third party that is a publicly funded program (other than Medicaid) of a State or local government.

TN No. 91-21 Supersedes TN No. 88-18	Approval Date 10/13/92	Effective Date	
TN No88-18		HCFA ID: 79855	

#### Revision: HCFA R/O March 1996

#### ATTACHMENT 2.6A Page 14aa

State/Territory <u>State of Hawaii</u>

Citation

Condition or Requirement

Medically Needy (continued)

States are permitted to exclude from incurred medical expenses those bills for services furnished more than three months before a Medicaid Application.

X Yes, the State elects to exclude such expenses.

No, the State does not elect to exclude such expenses.

• As a 209(b) state, Hawaii is . required to allow for incurred medical expenses regardless of when the expenses were incurred.

1902(a)(17) 435.831(g)(2) 436.831(g)(2)



Revision:	HCFA-PM-91-4 AUCUST 1991 State:	(BPD) Hawai	ATTACHMENT 2.6-A Page 15 OMB No.: 0938- I
Citati	ion		Condition or Requirement
	b.	Categori	cally Needy - Section 1902 (f) States
42 CFR 435.732	×	provisio	try applies the following policy under the ons of section 1902(f) of the Act. The ag amounts are deducted from income to the individual's countable income:
		(1) An	y SSI benefit received.
	3 1	ti 10 Wi	by State supplement received that is within the scope of an agreement described in section S16 or 1634 of the Act, or a State supplement thin the scope of section 902(a)(10)(A)(ii)(XI) of the Act.
, , ,		- <b>S</b> 1	ncreases in OASDI that are deducted under \$435.134 and 435.135 for individuals specify a that section, in the manner elected by the tate under that section.
			ther deductions from income described in this lan at <u>Attachment 2.6-A. Supplement 4</u> .
3		(5) II r	ncurred expenses for necessary medical and emedial services recognized under State law.
1902(a)(17 Act, P.L.	7) of the 100-203	by a this expenses party the	d expenses that are subject to payment. ind party are not deducted unless the s are subject to payment by a third hat is a publicly funded program (other dicaid) of a State or local government.

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				and the second	
TN No. <u>91-21</u> Supersedes TN No. <u>88-18</u>	Approval	Date	10/13/92	Effective	Date 10/01/91
TN No. 88-18				HCFA ID:	79852

Revision:	HCFA-PM-91-4 August 1991 State:	(BPD) Hawaii	ATTACHMENT 2.6-A Page 16a OMB No.: 0938-			
Citation		Condition or Requirement				
	5. Me	thods for D	etermining Resources			
1902(a)(1) 1902(a)(1) 1902(m)(1) and (C), 4 1902(r) 0	0)(C), )(B) and	under sect the agency treatment X The SSI	viduals. For aged individuals covered ion 1902(a)(10)(A)(11)(X) of the Act, y used the following methods for of resources: methods of the SSI. program. methods and/or any more liberal methods cribed in <u>Supplement 8b to ATTACHMENT</u> -A.			
		ind: the SSI desc Sup	hods that are more restrictive (except for ividuals described in section 1902(m)(1) of Act) and/or more liberal than those of the program. <u>Supplement 5 to ATTACHMENT 2.6-A</u> cribes the more restrictive methods and <u>plement 8b to ATTACHMENT 2.6-A</u> specifies the e liberal methods.			

TN No. 91-21 Supersedes	Approval Da	ate 10/13/92	Effective Date	10/01/91
TN No			HCFA ID: 7985	

Revision:	HCFA-PM-91-4 August 1991	(BPD	)	ATTACHMENT 2.6-A Page 17		
	State:	HAW	AII	OMB No.: 0938-		
Citation		Condition or Requirement				
		the liv	agency conside	ative financial responsibility rs only the resources of spous- household as available to		
1902(a)(10 1902(a)(10 1902(m)(1) 1902(r) of	)(C), (B), and	the ag	individuals. F ency uses the f ent of resource	or blind individuals ollowing methods for S:		
Act		<u>×</u>	The methods of	the SSI program.		
				/or any more liberal ed in <u>Supplement 8b to</u> A.		
		<u>×</u>	more liberal th <u>Supplement 5 to</u> more restrictiv	e more restrictive and/or an those of the SSI program. <u>ATTACHMENT 2.5-A</u> describe the e methods and <u>Supplement 8b tr</u> A specify the more liberal		
		In det	ermining relati	ve financial responsibility, -:		

In determining relative financial responsibility,  $z_{\rm R}^2$ agency considers only the resources of spouses living in the same household as available to spouses and  $z_{\rm R}^2$ resources of parents as available to children living with parents until the children become 21.

TN No. 91-21 Supersedes	Approval Date 10/13/92	Effective Date 10/01/91
TN No.		
		HCFA ID: 79858

Revision:	HCFA-PN-91-4	(BPD)
	AUCUST 1991	

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ATTACHMENT 2.6-A Page 18 OMB No.: 0938-

State: HAWAII

#### Citation

1902(a)(10)(A),

1902(a)(10)(C),

1902(m)(1)(B)

and (C), and 1902(r)(2) of

the Act

#### Condition or Requirement

d. <u>Disabled individuals. including individuals</u> <u>covered under section 1902(a)(10)(A)(11)(X) of</u> <u>the Act</u>. The agency uses the following methods for the treatment of resources:

- X The methods of the SSI program.
- _____ SSI methods and/or any more liberal methods described in <u>Supplement & to ATTACHMENT 2.6-A.</u>
- X Methods that are more restrictive (except for individuals described in section 1902(m)(1) of the Act) and/or more liberal that those under the SSI program. Nore restrictive methods are described in <u>Supplement 5 to ATTACHMENT 2.6-A</u> and more liberal methods are specified in <u>Supplement 8b to ATTACHMENT 2.6-A</u>.

In determining relative financial responsibility, the agency considers only the resources of spouses living in the same household as available to spouses and the resources of parents as available to children living with parents until the children become 21.

 Poverty level pregnant women covered under sections 1902(a)(10)(A)(1)(IV) and 1902(a)(10)(A)(11)(IX)(A) of the Act.

The agency uses the following methods in the treatment of resources.

- The methods of the SSI program only.
- The methods of the SSI program and/or any more liberal methods described in <u>Supplement 5s or</u> <u>Supplement 5b to ATTACHMENT 2.5-A</u>.

TN No. 91-21 Supersedes	Approval Date 10/13/92	Effective Date 10/01/91
TH No.	· · · · · · ·	HCFA ID: 79855

1902(1)(3) and 1902(r)(2) of the Act
1

ATTACHMENT 2.6-A Page 20 OMB No.: 0938-

State: <u>HAWAII</u>

Citation

Condition or Requirement

1905(p)(1)	5. h.	Qualified Medicare beneficiaries covered under
(C) and (D) and 1902(r)(2) of		<u>Section 1902(A)(10)(E)(1) of the Act</u>
the Act		The agency used the following methods for treatment of resources:.

_ The methods of the SSI program only.

X The methods of the SSI program and/or more libera methods as described in <u>Supplement Sb to</u> <u>ATTACHMENT 2.6-A</u>.

1905(s) of the · Act  For qualified disabled and working individuals_ covered under section 1902(a)(10)(E)(11) of the Act, the agency uses SSI program methods for the treatment of resources.

6. Resource Standard - Categorically Needy

- a. 1902(f) States (except as specified under items 6.c. and d. below) for aged, blind and disabled individuals:
  - X Same as SSI resource standards.
    - More restrictive.

The resource standards for other individuals are the same as those in the related cash assistance program

b. Non-1902(f) States (except as specified under items 6.c. and d. below)

The resource standards are the same as those in the related cash assistance program.

Supplement 8 to ATTACHMENT 2.6-A specifies for 1902(f) States the categorically needy resource levels for all covered categorically needy groups.

TN No. <u>91-21</u> Supersedes TN No.	Approval Date 10/13/02	Effective Date	
18 HQ.		HCFA ID: 7985E	

Revision:	HCFA-PM-91-4 AUGUST 1991 State:	(BPD) Hawaii	ATTACHMENT 2.6-A Page 21a OMB No.: 0938-
Citat	ion	Condition of	r Requirement
1902(m)(1 and (m)(2 of the Ac	)(B)	For aged and disabled in section 1902(m)(1) of t under section 1902(a)(1) Act, the resource stand	0)(A)(11)(X) of the
		X Same as SSI resou	rce standards.
			ally needy resource standards, than the SSI resource State covers the medically
		Supplement 2 to ATTACHN resource levels for the	ENT 2.6-A specifies the individuals.

TN No. 91-21 Supersedes	Approval Date	10/13/92	Effective	Date 10/01/91
TN No.			HCFA ID:	7985E

### ATTACHMENT 2.6-A Page 22

	State:Hawaii
Citation	Condition or Requirement
	7. Resource StandardMedically Needy
	a. Resource standards are based on family size.
1902(a)(10)(C)(l) of the Act	<ul> <li>A single standard is employed in determining resource eligibility for all groups.</li> </ul>
	C. In 1902(f) States, the resource standards is more restrictive than in 7.b. above for
	Aged
. «Ж. п.	Blind
	Disabled
	Supplement 2 to ATTACHMENT 2.6-A specifies the resource standards for all covered medically needy groups. If the agency chooses more restrictive levels under 7.c., Supplement 2 so indicates.
1902(a)(10)(E),	8. Resource Standard Qualified Medicare Beneficiaries, Specified Low-Income Medicare Beneficiaries and Qualifying Individuals
1905(p)(1)(C), 1905(p)(2)(B) and 1860D-14(a)(3)(D) of the Act	For qualified Madicare beneficiaries covered under section 1902(a)(10)(E)(I) of the Act, Specified Low-Income Medicare Beneficiaries covered under section 1902(a)(10)(E)(III) of the Act, and Qualifying Individuals covered under 1902(a)(10(E)(IV) of the Act, the resource standard is three times the SSI resource limit, adjusted annually since 1996 by the increase in the consumer price index.

 TN No.
 10-001

 Supersedes
 10.001

 TN No.
 91-21

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Effective Date: 01/01/10

ATTACHMENT 2.6-A Page 22a

### State: Hawaii

### 1902(a)(10)(E)(ii) and 1905(s) of the Act

41

9. Resource Standard - Qualified Disabled and Working Individuals

For qualified disabled and working individuals covered under section 1902(a)(10)(E)(ii) of the Act, the resource standard for an individual or a couple (in the case of an individual with a spouse) is two times the SSI resource limit.

TN No. <u>10-001</u> Supersedes TN No. <u>91-21</u>

Revision:	HCFA-PM-91-4 August 1991	(BPD)	ATTACHMENT 2.6-A Page 23
4	State:	HAWAII	OMB No.: 0938-
Citatio	n	-	Condition or Requirement
c	10.	Excess Resou	ICes
	۵.	Categorical Beneficiario Individuals	y Needy, Qualified Medicare s, and Qualified Disabled and Working
•		Any excess	esources make the individual ineligible.
(*)	Ъ.	Categorical	y Needy Only
		SSI.	tate has a section 1634 agreement with Receipt of SSI is provided for duals while disposing of excess ces.

c. Medically Needy

Any excess resources make the individual ineligible.

TN No. 91-21 Supersedes TN No.	Approval Da	te 10/13/92	Effective Date	10/01/91
		•	HCFA ID: 7985	z

Revision:	HCFA-PM-91-4 AUGUST 1991	(BPD)	ATTACHMENT 2.6-A Page 24
	State:	HAWAII	OMB NO.: 0938-
Citatio	>n	1114	Condition or Requirement
42 CFR 435.914	11.		Date of Eligibility
	а.		er Than Qualified Medicare Beneficiaries
		(1) For	the prospective period.
	1	4V44	wrage is available for the full month if the owing individuals are eligible at any time ing the month.
		<u>×</u>	<pre>.'Aged, blind, disabled. AFDC-related.</pre>
			arage is available only for the period ong the month for which the following viduals meet the eligibility requirements.
			Aged, blind, disabled. AFDC-related.
		(2) For	the retroactive period.
		indi	rage is available for three months before date of application if the following viduals would have been eligible had they ied:
			Aged, blind, disabled. AFDC-related.
		of t appl have	rage is evailable beginning the first day he third month before the date of ication if the following individuals would been eligible at any time during that h, had they applied
		<u>×</u>	Aged, blind, disabled. AFDC-related.
TN No. 91 Supersedes TN No.	1-21 Approv	val Date	0/13/92 Effective Date 10/01/91

HCFA ID: 7985E

### Revision: HCFA-PH-92-1 (HB) FEBRUARY 1992

TN No. 94-010 Supersedes ATTACHMENT 2.6-A Page 25

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

### State: HAWAII

EL	IGIBILITY CON	DITION	AND REQUIREMENTS
Citation(s)			Requirement
1920(b)(1) of the Act	_	_ (3)	For a presumptive eligibility period for pregnant women only.
			Coverage is available for ambulatory prenatal care for the period that begins on the day a qualified provide detarmines that a woman meets any of the income eligibility levels specifi in <u>ATTACHENT 2.6-A</u> of this approved plan. If the woman files an application for Medicaid by the last day of the month following the month
	÷		determination of presumptive eligibility, the period ends on the d that the State agency makes the determination of eligibility
	-		that application. If the woman does not file an application for Medicaid H the last day of the month following th month in which the qualified provider made the determination, the period end on that last day.
1902(e)(8) and 1905(a) of the Act	<u>Х</u> Ъ.	Act c the f in wh to be section	walified Medicare beneficiaries ed in section 1905(p)(1) of the overage is available beginning with irst day of the month after the month ich the individual is first determined a qualified Medicare beneficiary under on 1905(p)(1). The eligibility mination is valid for
			12 months
		(	6 months

9/22/94

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Approval Date

no more than 12 months)

8/1/411

Revision: 2 N	arch 1995	(MB) ATTACHMENT 2.6-A Page 26
Citation		Condition or Requirement
1902(a)(10) and 1902(f) o the Act	12. of	. Pre-OBRA 93 Transfer of Resources - Categorically and Medically Reedy, Qualified Me Beneficiaries, and Qualified Disabled and W Individuals
		The agency complies with the provisions of section of the Act with respect to the transfer of resources
		Disposal of recources at less than fair market affects eligibility for certain services as det in <u>Supplement 9 to Attachment 2.6-A</u> .
1917(c)	13.	Transfer of Assets - All eligibility groups
а ^н		The agency complies with the provisions of sec 1917(c) of the Act, as enacted by OBRA 93, with re to the transfer of assets.
	2 2 7	Disposal of assets at less than fair market was affects eligibility for certain services as detain <u>Supplement 9(a) to ATTACHMENT 2.6-A</u> , excepting tances where the egency determines that the transverse would work an undue hardship.
1917(d)	14.	Treatment of Trusts - All eligibility groups
		The agency complies with the provisions of sec 1917(d) of the Act, as amended by OBRA 93, with re- to trusts.
		The agency uses more restrictive methodolog under section 1902(f) of the Act, and appl those methodologies in dealing with trusts
		The agency meets the requirements in sect 1917(d)(X)(B) of the Act for use of Mil trusts. A
		The agency does not count the funds in a trust in instance where the agency determines that the trans would work an undue hardship, as described Supplement 10 to ATTACHMENT 2.6-A.

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TH No. 96-005 Supersectes TH No. 91-21

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Approval Date OCT 11 1986

Effective Date LAN & 1 1908

Revision: HCFA-PM-97-3 December 1997 State: <u>HAWAII</u>	ATTACHMENT 2.6-A Page 26a OMB No.:0938-0673
Citation	Condition or Requirement
1924 of the Act 13.	The agency complies with the provisions of §1924 with respect to income and resource eligibility and posteligibility determinations for individuals who are expected to be institutionalized for at least 30 consecutive days and who have a spouse living in the community.
	When applying the formula used to determine the amount of resources in initial eligibility determinations, the State standard for community spouses is:
	x the maximum standard permitted by law;
	the minimum standard permitted by law; or
	S a standard that is an amount between the minimum and the maximum.

Approval Date 12/1/95

#### Revision: HCPA-PH-92-1 (88) FEBRUARY 1992

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### SUPPLEMENT 1 TO ATTACHMENT 2.6-Page 5

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

States HAWAII

# INCOME BLIGIBILITY LEVELS (Continued)

Aged and Disabled Individuals 3.

The levels for determining income eligibility for groups of aged and disabled individuals under the provisions of section 1902(m)(3) of th

Based on 100 percent of the official Federal income poverty line.

Family Size		an ancome poverty	11
		Income Level	
		8 <u>*</u>	
		\$	
		\$ <del>*</del>	
		\$ <u>*</u>	

If an individual receives a title II benefit, any amount attributable to the most recent increase in the monthly insurance benefit as a resultofa title II COLA is not counted as income during a "transition period" beginning with January, when the title II benefit for December is received, and ending with the last day of the month following the month of publication of the revised annual

For individuals with title II income, the revised poverty levels are not effective until the first day of the month following the end of the transition period.

For individuals not receiving title II income, the revised poverty levels are effective no later than the beginning of the month followin the date of publication.

BCTA ID:

7985E

*Amount equal to 100% of the federal poverty level for a family of applicable size and updated annually as published in the Federal Register.

1	TN No. <u>92-15</u> Supersedes TN No. <u>91-21</u>	Approval Date	10/29/92	Effective Date	7/1/92
				ALLOCTIVE DATE -	1/4/36

Revision: HCFA-PM-91-4 (BPD) AUGUST 1991

SUPPLEMENT 1 TO ATTACHMENT 2.6-A Page 6 OMB No.: 0938-

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT.

State: HAWAII

# INCOME ELIGIBILITY LEVELS (Continued)

C. QUALIFIED MEDICARE BENEFICIARIES WITH INCOMES RELATED TO FEDERAL POVERTY LEVEL

The levels for determining income eligibility for groups of qualified Medicare beneficiaries under the provisions of section 1905(p)(2)(A) of the Act are as follows:

- 1. NON-SECTION 1902(f) STATES
- a. Based on the following percent of the official Federal income poverty level:

Eff. Jan. 1, 1989: // 85 percent // percent (no more than 100) Eff. Jan. 1, 1990: // 90 percent // percent (no more than 100) Eff. Jan. 1, 1991: 100 percent Eff. Jan. 1, 1992: 100 percent

b. Levels:

Family Size

Income Levels

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*Amount equal to 100% of the federal poverty level for a family of applicable size, as revised annually in the Federal Register.

TN No. <u>91-21</u> Supersedes TN No.	Approval Date	10/13/92	Effective	Date 10 /01/91
14 40.			HCFA ID:	7985E

Revision: HCFA-PM-91-4 AUGUST 1991

(BPD)

SUPPLEMENT 1 TO ATTACHMENT 2.6-A Page 7 OMB No.: 0938-

### STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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HAWAII State: _

# INCOME ELIGIBILITY LEVELS (Continued)

- QUALIFIED MEDICARE BENEFICIARIES WITH INCOMES RELATED TO FEDERAL POVERTY C. LEVEL
- SECTION 1902(1) STATES WHICH AS OF JANUARY 1, 1987 USED INCOME STANDARDS 2. MORE RESTRICTIVE THAN SSI
- Based on the following percent of the official Federal income poverty ð.---level:

Eff.	Jan.	1,	1989:	$\square$	80 percent	<u>/X/</u>	100	percent	(no	Bore	than	10(
Bff.	Jan.	1,	1990:	$\square$	85 percent	127	100	percent	(no	Rore	than	101
Eff.	Jan.	1,	1991:	$\Box$	95 percent	мī́7	100	percent	(no	BOIS	than	100
Eff.	Jan.	1,	1992:	100	percent			127	•			

b. Levels:

Family Size

### Income Levels

\$_	-		_ L	
\$]		V.		

*Amount equal to federal poverty level for a family of applicable size, as revised annually a in the Federal Register

	Approval Dat	10/13/92	Effective	Dete 10/01/91
TN NO.	,	· · ·	HCFA ID:	79858

### REVISION: HCFA-PM-91-4 (BPD) August 1991

SUPPLEMENT 1 TO ATTACHMENT 2.6-A Page 8 OMB No.: 0938-

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State ____

HAWAII

# INCOME LEVELS (Continued)

### D. MEDICALLY NEEDY

_X_ Applicable to all groups.

Applicable to all groups except those specified below. Excepted group income levels are also listed on an Attached page 3.

(1)	(2)	(3)		
1.00		()	(4)	(5)
Family Size	Net income level protected for maintenance for <u>one</u> month	Amount by which Column (2) exceeds limits specified in CFR 435.1007 ^{1/}	Net income level for persons living in rural areas for months	Amount by which Column (4) exceeds limits specified in 42 CFR 435.1007 ^{1/2}
-	Urban only			
	Urban & rural			
<b>1</b> - 0 Te	\$ 469	s		2
2	\$ 632	S	3	5
3	\$ 795	S	5	\$
4	\$ 958	\$	5	\$
For each Additional Person,			8	5
\dd:	\$163			

Ц

The agency has methods for excluding from its claim for FFP payments made on behalf of individuals whose income exceeds these limits.



### REVISION: HCFA-PM-91-4 (BPD) August 1991

SUPPLEMENT 1 TO ATTACHMENT 2.6-A Page 9 OMB No.: 0938-

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State HAWAII

# **INCOME LEVELS (Continued)**

### D. MEDICALLY NEEDY

X Applicable to all groups. ____ Applicable to all groups except those specified below. Excepted group income levels are also listed on an attached page 3.

(1)	(2)	(3)	(4)	
Family Size	Net income level protected for maintenance for one month	Amount by which Column (2) exceeds limits specified in CFR	Net income level for persons living in rural areas for	(5) Amount by which Column (4) exceeds limits specified in
	urban only urban & rural	435.1007 ^{1/2}	months	42 CFR 435.1007 ¹
5	\$ 1,121			
6	\$ 1,284	<u>e</u>	S	\$
7	\$ 1.447	2	5	S
3	\$ 1.610	2	5	S
	\$ 1,772	\$	3	\$
0	\$ 1.935	2	3	
or each dditional erson,			5	
dd:	\$ 163			

¥

The agency has methods for excluding from its claim for FFP payments made on behalf of individuals whose income exceeds these limits.

Revision: HCFA-PM-91-4 (BPD) AUGUST 1991 SUPPLEMENT 2 TO ATTACHMENT 2.6-A Page 6 OMB No.: 0938-

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: HAWAII

4. Aged and Disabled Individuals

 $\sqrt{X/X}$  Same as SSI resource levelst for an individual or a couple.

// More restrictive than SSI levels and are as follows:

Family Size		Resource Level
<b>i</b>		
	2	

<u>IXI</u>

Same as medically needy resource levels (applicable only if State has a medically needy program)

	Approval Date	10/13/92	Effective	Date 10/01/91
TN No.	3. A		HCFA ID:	79852

SUPPLEMENT 2 TO ATTACHMENT 2.6-A Page 7 OMB No.: 0938-

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

### State: HAWAII

### RESOURCE LEVELS (Continued)

B. MEDICALLY NEEDY

Applicable to all groups -

•

D

7 Except those specified below under the provisions of section 1902(f of the Act.

Resource Level
2.000
3,000
3,250
3,500
3,750
4,000
4,250
4,500
4,750
5,000
250

TN No. <u>91-21</u> Supersedes	Approval Date 10/13/92	Effective Date 10/01/91
TN No.		HCFA 1D: 7985E

Revision: HCFA-PM-85-3

SUPPLEMENT 3 to ATTACHMENT 2.6-A Page 1

# STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State_____HAWAII

(BERG)

# REASONABLE LIMITS ON AMOUNTS FOR NECESSARY MEDICAL OR REMEDIAL CARE NOT COVERED UNDER MEDICALD

The deduction for medical and remedial care expenses that were incurred as the result of the imposition of a transfer of asset penalty period is limited to zero.

TN No. 09-010				
Supersedes TN No. 85-9	Approval Date:	AUG-2-3 2010 Effective Date:	10/01/09	

HCFA ID: 4093E/0002P

SUPPLEMENT 4 TO ATTACHMENT 2.6-A Page 1 OMB No.: 0938-

#### STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

#### State: HAWAII

#### METHODS FOR TREATMENT OF INCOME THAT DIFFER FROM THOSE OF THE SSI PROGRAM

(Section 1902(f) more restrictive methods and criteria and State supplement criteria in SSI criteria States without section 1634 agreements and in section 1902(f) States. Use to reflect more liberal methods only if you limit to State supplement recipients. DO NOT USE this supplement to reflect more liberal policies that you elect under the authority of section 1902(r)(2) of the Act. Use Supplement 8a for section 1902(r)(2) methods.)

The methodology for treatment of income differs from the SSI program in the following areas where Hawaii is more restrictive.

1. Money received as repayment on loans is not disregarded.

2. Child support payments are counted as unearned income.

3. \$10 exclusion for infrequent or irregular earned income is not allowed.

4. VA aid and attendance payments are not disregarded.

TN No. 91-21 Supersedes TN No. 88-13	Approval	Date	10/13/92	Effective	Date 10/01/91
TH No. <u>88-13</u>				HCFA ID:	7985E

SUPPLEMENT 5 TO ATTACHMENT 2.6-A Page 1 OMB No.: 0938-

# STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

### State: <u>HAWAII</u>

### MORE RESTRICTIVE METHODS OF TREATING RESOURCES THAN THOSE OF THE SSI PROGRAM - SECTION 1902(f) STATES ONLY

The methodology for treatment of resources differs from the SSI program in the following areas where Hawaii is more restrictive.

- 1. The value of property other than home property including business property is counted.
- 2. The equity value of life insurance policies are counted. Equity value of a life insurance policy shall be determined by subtracting any outstanding loans or encumbrances from the cash value of the policy.

3. Income tax refunds are counted as a resource in the month of receipt.

TN No.	13-004b						6
Supersedes TN No.	91-21	Approval )	Date:	09/30/2013	Effective	Date:	01/01/2014

Revision: HCFA-PM-91-4 (BPD) AUGUST 1991 SUPPLEMENT 54 TO ATTACHMENT 2.6-A Page 1 OMB No.: 0938-

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

# State: HAWAII

METHODS FOR TREATMENT OF RESOURCES FOR INDIVIDUALS WITH INCOMES RELATED TO FEDERAL POVERTY LEVELS

(Do not complete if you are electing more liberal methods under the authority of section 1902(r)(2) of the Act instead of the authority specific to Federal poverty levels. Use Supplement 8b for section 1902(r)(2) methods.)

Optional coverage categorically needy

- Pregnant women and children no limit on resources.
- Aged and disabled not to exceed the maximum amount allowed under the State's medically needy program.

	Date	10/13/92	Effective	Date	10/01/91
TN NO			HCFA ID:	79852	

2.6-A
ATTACHMENT
6 JO
SUPPLEMENT

State: Hawaii

Standards for Optional State Supplementary Payments

Payment Category	Administered by		Inco	Income Level		Income Disregards
(Reasonable Classification)	Federal State	Gross*	*	Net**		Employed
		1 person	Couple	1 person	Couple	
(1)	(2)	(3)		(4)		(5)
A, B, D IN DOMICILIARY CARE:	X					
LEVEL I	\$733.00 \$651.90	\$2,199.00	N/A	\$1,384.90	N/A	
LEVEL II	\$733.00 \$759.90	\$2,199.00	N/A	\$1,492.90	N/A	

*Gross income, before deductions allowed by SSI, cannot exceed 300% of the FBR. **Net income, after deductions allowed by SSI, cannot exceed the SSI/SSP payment limit NOTE:

TN No. Supersedes TN No.

15-001

Effective Date: 03/12/15

01/01/2015

14 - 001

Approval Date:

Revision: HCFA-PM-91-6 (BPD) August 1991 SUPPLEMENT 7 TO ATTACHMENT 2.6 Page 1 OMB No.: 0938-

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: HAWAII

1.

INCOME LEVELS FOR 1902(1) STATES - CATEGORICALLY NEEDY WHO ARE COVERED UNDER REQUIREMENTS MORE RESTRICTIVE THAN SSI

TH No. <u>91-21</u> Supersedes TH No. <u>89-7</u>	Approval	Date	10/13/92	Effective	Date
TH NO. 03-7				HCFA ID:	7985E

Revision: HCFA-PM-91-4 (BPD) AUGUST 1991 SUPPLEMENT 8 TO ATTACHMENT 2.6-A Page 1 OMB No.: 0938-

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: HAWAII

RESOURCE STANDARDS FOR 1902(1) STATES - CATEGORICALLY NEEDY

Same as the medically needy

Family Size	Resource Level
1	\$2,000
2	3,000
1	

For each additional person, add \$250 to the resource level for 2 persons.

TN No. 91-21 Supersedes	Approval	Date	10/13/92	Effective	Date 10/01/91	
TH No.					70059	

Revision: HCFA-PM-91-4 August 1991

State:

(BPD)

SUPPLEMENT 8a to ATTACHMENT 2.6-A Page 1 OMB NO.: 0938-

# STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

# HAWAII

# MORE LIBERAL METHODS OF TREATING INCOME UNDER SECTION 1902(r)(2) OF THE ACT

X Section 1902(f) State

Non-Section 1902(f) State

1. For optional targeted low income children covered under 1902(a)(10)(A)(ii)(XIV) of the Act subject to 1902(r)(2):

Disregard the difference in countable income between 300% of the Federal Poverty Level (FPL) and 250% FPL for optional targeted low income children covered under 1902(a)(10)(A)(ii)(XIV) of the Act.

2. Wages paid by the Census Bureau for temporary employment related to census activities are excluded for the eligibility groups:

# Mandatory Categorically Needy Eligibility Groups

TN No. 08-017 Supersedes Approval Date: FEB 1 3 2009	Effective Date: 10/01/2008
17. Specified Low Income Beneficiaries. TN No. 08-017	§1902(a)(10)(E)(iii)
10. Qualified Medicare Beneficiaries	§1902(a)(10)(E)(i), §1905(p)(1)
15. Qualified Disabled and Working Individuals.	§1902(a)(10)(E)(ii), §1905(s)
14. Early widows/widowers.	§1634(d), §1935
13. Disabled adult children.	§1634(c), §1935
12. Disabled widows/widowers.	§1634(b), §1935
11. Pickle amendment -Would be eligible for SSI if title II COLAs were deducted from income.	Section 503 of P.L. 94-566
10. Disabled individual whose earnings are too high to receive SSI cash benefit.	§1902(a)(10)(A)(i)(II), §1905(q)
<ol> <li>Disabled individual whose earnings are too high to receive SSI cash benefit</li> </ol>	§1619(Ъ)
8. Disabled individual whose earnings exceed SSI substantial gainful activity level.	§1619(a)
7. Poverty level children under age 19.	\$1902(a)(10)(A)(i)(VII), \$1902(l)(1)(D)
6. Poverty level children under age 6.	§1902(a)(10)(A)(i)(VI), §1902(I)(1)(B)
5. Poverty level infants.	\$1902(a)(10)(A)(i)(IV), \$1902(l)(1)(A) \$1902(a)(10)(A)(i)(IV), \$1902(l)(1)(B)
4. Poverty level pregnant women.	\$1902(a)(10)(A)(i)(III), \$1905(n)(2) \$1902(a)(10)(A)(i)(IV), \$1902(i)(1)(A)
3. Qualified children.	<pre>\$1902(a)(10)(A)(i)(III), \$1905(n)(1) \$1902(a)(10)(A)(i)(III), \$1905(n)(2)</pre>
2. Qualified pregnant women.	\$1902(a)(10)(A)(j)(III) \$1005()(j)
change in definition of disability.	§1902(a)(10)(A)(i)(II)
1. Children no longer eligible for SSI because of	

TN No. 08-004

I J ZUUJ Effective Date: Approval Date:

10/01/2008

Re	vision:	HCFA-PM-91-4 August 1991	(BPD)	Page 2	MENT 8a ).: 0938-	to ATTACHMENT 2.	6-A
1	8. Qual	ified Individuals -I.		\$1	002(a)(10)		
C	)ptiona	I Categorically Needy	v Eligibility G	roung	902(a)(10)	)(E)(iv)(I)	
1	. Meet the ap	the income and resour ppropriate cash assista FDC).	rce requiremen	ts of 81	902(a)(10)	(A)(ii)(I)	
2.	requir	ld meet the income and rements of AFDC if ch from earnings rather th cy.	hild care costs w	§19 were	02(a)(10)	(A)(ii)(II)	
	Would or SSI institu receiv institu	d be eligible for cash a l) if they were not in a ation. Receiving, or wo re if they were not in a ation, a State supplement	medical ould be eligible medical nt payment	to	02(a)(10)(	(A)(ii)(IV)	
	adopti	duals under age 21 wh on agreements.			02(a)(10)(	A)(ii)(VIII)	
	Aged o does no poverty	or disabled individuals ot exceed 100 percent y level.	of the Federal		<b>)2(a)(10)(</b>	A)(ii)(X)	
	an option	ing only an optional S is more restrictive than onal State supplement	n the criteria fo under title XV	r	92(a)(10)(	A)(ii)(XI)	
7.	Option	al targeted low income	e children.		2(a)(10)(A	A)(ii)(XIV)	
8.	Medica	lly Needy.	0:2	§190	2(a)(10)((	C), §1902(a)(10)(C)(i)(	III)

SUPPLEMENT 8a to ATTACHMENT 2.6-A Page 3

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

### State: <u>Hawaii</u>

MORE LIBERAL METHODS OF TREATING INCOME UNDER SECTION 1902(r)(2) OF THE ACT

3. For children under Section 1902(a)(10)(i)(VII) and 1902(1)(1)(D)of the Act (children who were born after September 30, 1983 and have attained age 6 but have not attained age 19), subject to 1902(r)(2):

Disregard the difference in countable income between 133% of the Federal Poverty Level (FPL) and 100% FPL for children covered under Sections 1902(a)(10)(i)(VII) and 1902(l)(1)(D)of the Act.

TN No.	13-010				
Supersedes		Approval Date:	02/12/2014	Effective Date:	10/01/2013
TN No.	NEW				10/01/2013

SUPPLEMENT 8a to ATTACHMENT 2.6-A Page 4

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

### State: <u>Hawaii</u>

MORE LIBERAL METHODS OF TREATING INCOME UNDER SECTION 1902(r)(2) OF THE ACT

4. Disregard all income for 2101(f)-like reasonable classification of children described in Supplement 1 to Attachment 2.2-A, page 2.

TN No.	13-011				·····	
Supersedes		Approval	Date:	03/13/2014	Effective Date:	12/31/2013
TN No.	NEW					

Revision: HCFA-PM-August 199

HCFA-PM-91-4 (BPD) August 1991 SUPPLEMENT 8a to ATTACHMENT 2.2-A Page 1 6 OMB No.: 0938

### STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State:

HAWAII

MORE LIBERAL METHODS OF TREATING INCOME UNDER SECTION 1902 (r) (2) OF THE ACT*

Section 1902 (f) State

Non-Section 1902 (f) State

* More liberal methods may not result in exceeding gross income limitations under section 1903(f).

TN No. 00-006	*s1				AND 1 40	26
Supersedes	Approval Date:	JUL	11	1000 Effective Date:	APRIA	
TN No.	F.,			HCFA ID: 7	985E	

SUPPLEMENT 8b TO ATTACHMENT 2.6-A Page 1 OMB No.: 0938-

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

### State: <u>HAWAII</u>

MORE LIBERAL METHODS OF TREATING RESOURCES UNDER SECTION 1902(r)(2) OF THE ACT

Section 1902(f) State

Non-Section 1902(f) State

#### For all ABD groups:

 The equity value of all motor vehicles such as cars, trucks, vans, campers, motorcycles, and mobile homes are exempt from consideration toward the personal reserve, regardless of the value or the use of the vehicles, with the exception of all watercrafts and air transportation vehicles, such as boats, airplanes, and helicopters that will continue to be considered toward the personal reserve.

TN No.	13-004b				
Supersedes		Approval Date:	09/30/2013	Effective Date:	01/01/2014
TN NO.	03-001				

Revision: HCFA-PM-91-4 AUGUST 1991

(BPD)

SUPPLEMENT 9 TO ATTACHMENT 2.6-A Page 1 OMB No.: 0938-

# STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

### State: HAWAII

#### TRANSFER OF RESOURCES

1902(f) and 1917 of the Act

.

- 17 The agency provides for the denial of eligibility by reason of disposal of resources for less than fair market value.
  - A. Except as noted below, the criteria for determining the period of ineligibility are the same as criteria specified in section 1613(c) of the Social Security Act (Act).
    - 1. Transfer of resources other than the home of an individual who is an inpatient in a medical institution.

a. [7] The agency uses a procedure which provides for a total period of ineligibility greater than 24 months for individuals who have transferred resources for less than fair market value when the uncompensated value of disposed of resources exceeds \$12,000. This period bears a reasonable relationship to the uncompensated value of the transfer. The computation of the period and the reasonable relationship of this period to the uncompensated value is described as follows:

TN No. 91-21 Supersedes TN No. 85-5	Approval	Date	10/13/92	Effective	Date 10/01/91
TN No. 85-5				HCFA ID:	79858

Revision: HCFA-PM-91-4 (BPD) AUGUST 1991

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SUPPLEMENT 9 TO ATTACHMENT 2.6-A Page 2 OMB No.: 0938-

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State:	HAWAII		

b. // The period of ineligibility is less than 24 months, as specified below:

c. []

The agency has provisions for waiver of denial of eligibility in any instance where the State determines that a denial would work an undue hardship.

	Approval	Date	10/13/92	Effective	Date _	10/01/91
TN No				HCFA ID:	7985E	

Revision: HCFA-PM-91-4 AUGUST 1991

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SUPPLEMENT 9 TO ATTACHMENT 2.6-A Page 3 OMB No.: 0938-

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: _____HAWAII

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(BPD)

Transfer of the home of an individual who is an inpatient in a medical institution.

- // A period of ineligibility applies to inpatients in an SNF, ICF or other medical institution as permitted under section 1917(C)(2)(B)(1).
  - a. Subject to the exceptions on page 2 of this supplement, an individual is ineligible for 24 months after the date on which he disposed of the home. However, if the uncompensated value of the home is less than the average amount payable under this plan for 24 months of care in an SNF, the period of ineligibility is a shorter time, bearing a reasonable relationship (based on the average amount payable under this plan as medical assistance for care in an SNF) to the uncompensated value of the home as follows:

	Approval Date _	10/13/92	Effective	Date _	10/01/91
TN No. 85-5			HCFA ID:	7985E	

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SUPPLEMENT 9 TO ATTACHMENT 2.6-A Page 4 OMB No.: 0938-

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State:	HAWAII

b. <u>/</u> Subject to the exceptions on page 2 of this supplement, if the uncompensated value of the home is more than the average amount payable under this plan as medical assistance for 24 months of care in an SNF, the period of ineligibility is more than 24 months after the date on which he disposed of the home. The period of ineligibility bears a reasonable relationship (based upon the average amount payable under this plan as medical assistance for care in an SNF) to the uncompensated value of the home as follows:

	Approval Date	10/13/92	Effective	Date 10/01/91
TN No	a.		HCFA ID:	79852

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SUPPLEMENT 9 TO ATTACHMENT 2.6-A Page 5 OMB No.: 0938-

### STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State:	 30	HAWAII				_			
	No if-	individual	15	ineligible	by	reason	of	item	X.2

- (1) A satisfactory showing is made to the agency (in accordance with any regulations of the Secretary of Health and Human Services) that the individual can reasonably be expected to be discharged from the medical institution and to return to that home:
- (ii) Title to the home was transferred to the individual's spouse or child who is under age 21, or (for States eligible to participate in the State program under title XVI of the Social Security Act) is blind or permanently and totally disabled or (for States not eligible to participate in the State program under title XVI of the Social Security Act) is blind or disabled as defined in section 1614 of the Act;
- (111) A satisfactory showing is made to the agency (in accordance with any regulations of the Secretary of Health and Human Services) that the individual intended to dispose of the home either at fair market value or for other valuable consideration; or
  - (iv) The agency determines that denial of eligibility would work an undue hardship.

	Approval Date	10/192	Effective Date 10/01/01
TN No. 85-5			HCFA ID: 79858

Revision: HCFA-PM-91- (BPD) AUGUST 1991

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SUPPLEMENT 9 TO ATTACHMENT 2.6-A Page 6 OMB No.: 0938-

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: HAWAII

3. 1902(f) States

Under the provisions of section 1902(f) of the Social Security Act, the following transfer of resource criteria more restrictive than those established under section 1917(c) of the Act, apply:

- B. Other than those procedures specified elsewhere in the supplement, the procedures for implementing denial of eligibility by reason of disposal of resources for less than fair market value are as follows:
  - 1. If the uncompensated value of the transfer is \$12,000 or less:
  - 2. If the uncompensated value of the transfer is more than \$12,000:

	Approval Date	10/13/92	Effective	Date 10/01/91
TN No. 85-5			HCFA ID:	79852

Revision: HCFA-PM-91-4 AUGUST 1991

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SUPPLEMENT 9 TO ATTACHMENT 2.6-A Page 7 ONB No.: 0938-

### STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

### State: ______ HAWAII

(BPD)

3. If the agency sets a period of ineligibility of less than 24 months and applies it to all transfers of resources (regardless of uncompensated value):

### 4. Other procedures:

An institutionalized spouse who (or whose spouse) transferred resources for less than fair market value shall not be found ineligible for nursing facility services, for a level of care in a medical institution equivalent to that of nursing facility services, or for home and community-based services where the State determines that denial of eligibility would work an undue hardship under the provision of Section 1917(c) (2) (D) of the Social Security Act.

TN No. 91-21 Supersedes	Approval	Date	10/13/92	Effective	Date	10/01/91
TN No				HCTA ID:	79858	
Addendum to Supplement 9 to Attachment 2.6-A Page 1

#### STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

#### STATE: HAWAII

#### TRANSFER OF RESOURCES

Section 1917(C) of the Act (1) The agency provides for a period of ineligibility for nursing facility services and for a level of care in a medical institution equivalent to that of nursing facility services and for services under Section 1915(c) of the Act in the case of an institutionalized individual (as defined in item (3), on page 3 of this Addendum to Supplement 9 to Attachment 2.6-A) who, or whose spouse, transfers resources (as defined in item (4), on page 3 of this Addendum to Supplement 9 to Attachment 2.6-A) for less than fair market value at any time during or after the 30-month period immediately before the date the individual becomes an institutionalized individual or, if later, the date the institutionalized individual applies for medical assistance.

Except as provided in item (2), on page 2 and 3 of this Addendum to Supplement 9 to Attachment 2.6-A, the period of ineligibility shall begin with the month in which such resources were transferred and the number of months in such period shall be equal to the lesser of-

- (A) 30 months, or
- (B) the total uncompensated value of the resources so transferred, divided by the average cost, to a private patient at the time of the application, of nursing facility services in the State.

TN No. <u>91-05</u> Supersedes TN No.

Approval Date 12/16/91

Effective Date 07/01/91

Addendum to Supplement 9 to Attachment 2.6-A Page 2

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

#### STATE: HAWAII

(2) An individual shall not be ineligible for medical assistance by reason of a transfer (as provided on page 1 of this Addendum to Supplement 9 to Attachment 2.6-A) to the extent that -

(A) the resources transferred were a home and title to the home was transferred to -

(i) the spouse of such individual;

(ii) a child of such individual who is under age 21 or is blind or disabled as defined in Section 1614 of the Act;

(iii) a sibling of such individual who has an equity interest in such home and who was residing in such individual's home for a period of at least one year immediately before the date the individual becomes an institutionalized individual; or

(iv) a son or daughter of such individual (other than a child described in item (2) (A) (ii) above) who was residing in such individual's home for a period of at least 2 years immediately before the date the individual becomes an institutionalized individuals, and who (as determined by the State) provided care to such individual which permitted such individual to reside at home rather than in such an institution or facility;

- (B) the resources were transferred(i) to or from (or to another for the sole benefit of) the individual's spouse, or
  (ii) to the individual's child described in item
  (2) (A) (ii), above;
- (C) a satisfactory showing is made to the State (in accordance with any regulations promulgated by the Secretary) that-

(i) the individual intended to dispose of the resources either at fair market value, or for other valuable consideration; or

(ii) the resources were transferred exclusively for a purpose other than to qualify for medical assistance; or

(D) the State determines that denial of eligibility would work an undue hardship, under the provisions of Section 1917(c)(2)(D) of the Social Security Act.

TN No. <u>91-05</u> Supersedes TN No.

Approval Date 12/16/91

Effective Date 07/01/91

Addendum to Supplement 9 to Attachment 2.6-A Page 3

## STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

#### STATE: <u>HAWAII</u>

(3) For purposes of Section 1917(c) of the Act, the term "institutionalized individual" means an individual who is an inpatient in a nursing facility, who is an inpatient in a medical institution and with respect to whom payment is made based on a level of care provided in a nursing facility, or who is described in Section 1902(a)(10)(A)(ii)(VI) of the Act.

(4) The State will not provide for any period of ineligibility for an individual due to transfer of resources for less than fair market value except in accordance with subsection 1917(c) of the Act.

(5) For purposes of Section 1917(c) of the Act, the term "resources" has the meaning given such term in Section 1613 of the Act, without regard to the exclusion described in subsection (a)(1) thereof.

TN No. <u>91-05</u> Supersedes TN No.

Approval Date <u>12/16/91</u>

Effective Date 07/01/91

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: HAWAII

#### TRANSFER OF ASSETS

1917(c)

ł

The agency provides for the denial of certain Nedicaid services by reason of disposal of assets for less than fair market value.

1. Institutionalized individuals may be denied certain Medicaid services upon disposing of assets for less than fair market value on or after the look-back date.

The agency withholds payment to institutionalized individuals for the following services:

Payments based on a level of care in a sursing facility;

Payments based on a nursing facility level of care in a medical institution;

Home and community-based services under a 1915 waiver.

2. Non-institutionalised individuals:

(10)

The agency applies these provisions to the following noninstitutionalised eligibility groups. These groups can be no more restrictive than those set forth in section 1905(a) of the Social Security Act:

The agency withholds payment to non-institutionalized individuals for the following services:

Home health services (section 1905(a)(7));

Home and community care for functionally disabled and elderly adults (section 1905(a)(22));

Personal care services furnished to individuals who are not inpatients in certain medical institutions, as recognized under agency law and specified in section 1905(a)(24).

The following other long-term care services for which medical assistance is otherwise under the agency plan:

TH No. 96-005 Supersedes	Approval Date	OCT 1 1 1996	Effective Date	WAN 01 1998
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State: HAWAII

#### TRANSFER OF ASSETS

- 3. Penalty Date -- The beginning date of each penalty period imposed for an uncompensated transfer of assets is:
  - the first day of the south is which the asset was transferred;
    - the first day of the month following the month of transfer.

Penalty Period - Institutionalized Individuals-4. agency uses:

X the average monthly cost to a private patient of mursing facility services in the agency;

the average monthly cost to a private patient of mursing facility services in the community in which the individual is institutionalized.

#### Penalty Period - Non-institutionalised Individuals---S.

The agency imposes a penalty period determined by using the same method as is used for an institutionalized individual, including the use of the average monthly cost of nursing facility services;

imposes a shorter penalty period than would be imposed for institutionalized individuals, as outlined below:

ь.

State: HAWAII

#### TRANSFER OF ASSETS

- 6. <u>Penalty period for amounts of transfer less than cost of nursing</u> facility care-
  - a. Where the amount of the transfer is less than the monthly cost of nursing facility care, the agency:
    - X does not impose a penalty;
    - imposes a penalty for less than a full month, based on the proportion of the agency's private nursing facility rate that was transferred.
    - Where an individual makes a series of transfers, each less than the private nursing facility rate for a month, the agency:

X does not impose a penalty;

- imposes a series of penalties, each for less than a full month.
- 7. Transfers made so that penalty periods would overlap--The agency:
  - _____ totals the value of all assets transferred to produce a single penalty period;
  - X calculates the individual penalty periods and imposes them sequentially.
- - X assigns each transfer its own penalty period;

uses the method outlined below:

TN No. Superse	96-005 des	Approval	Date OCT	1 1 1998	Effective	Date	MAN 01 100
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State:

#### TRANSFER OF ASSETS

- Penalty periods transfer by a spouse that results in a penalty 9. period for the individual --
  - The agency apportions any existing penalty period between (....) . the spouses using the method outlined below, provided the spouse is eligible for Medicaid. A penalty can be assessed against the spouse, and some portion of the penalty against the individual remains.

When both spouses are eligible for Medicaid and both spouses are institutionalized, the State will use the following method to apportion the penalty period:

- * Apportion the penalty period equally between the spouses;
- * If one spouse dies or leaves the insitution prior to the expiration of their share of the penalty period, the remainder of the penalty will be assigned to the spouse who is still insitutionalized;
- * The penalty months served by the institutionalized spouses shall not exceed the length of the original penalty period.
- If one spouse is no longer subject to a penalty, the (b) remaining penalty period must be served by the remaining spouse.
- 10. Treatment of income as an asset-When income has been transferred as a lump sum, the agency will calculate the penalty period on the lump sum value.

The agency will impose partial month penalty periods.

When a stream of income or the right to a stream of income has been transferred, the agency will impose a penalty period for each income payment.

- For transfers of individual income payments, the agency will impose partial month penalty periods.
- X For transfers of the right to an income stream, the agency will use the actuarial value of all payments transferred.
  - The agency uses an alternate method to calculate penalty periods, as described below:

#### Revision: HCFA-PM-95-1 (MB) March 1995

SUPPLEMENT 9(a) to ATTACHMENT 2.6-A Page 5

State: HAWAII

#### TRANSFER OF ASSETS

- 11. <u>Imposition of a penalty would work an undue hardship</u> The agency does not apply the transfer of assets provisions in any case in which the agency determines that such an application would work an undue hardship. The agency will use the following procedures in making undue hardship determinations:
  - a) Notify the individuals subject to the transfer of assets penalty that there are exceptions to the transfer of assets penalty due to undue hardship.
  - b) If a waiver for undue hardship is requested, the individual seeking the waiver must provide documentation of efforts taken to recover the transferred asset.
  - c) Individuals will be notified of the disposition of their request for a waiver of the transfer of asset penalty. Individuals who are denied the waiver must be informed of their right to a fair hearing.

The following criteria will be used to determine whether the agency will not count assets transferred because the penalty would work an undue hardship:

- a) The recoverable amount of the transferred asset is depleted below State resource standard; or
- b) The transferred asset has been converted to another asset that is not liquid or redeemable; or
- c) The return of the transferred property would put the receiving party in serious risk of deprivation such as the loss of income or assets that would qualify the receiver for medical assistance; or
- d) Unable to locate the receiving party of the transferred asset after exhaustive search efforts.

Approval Date OCT 11 1998

#### STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State HAWAII

#### TRANSFER OF ASSETS

1917(c)

FOR TRANSFERS OF ASSETS FOR LESS THAN FAIR MARKET VALUE MADE ON OR AFTER FEBRUARY 8, 2006, the agency provides for the denial of certain Medicaid services.

1. Institutionalized individuals are denied coverage of certain Medicaid services upon disposing of assets for less than fair market value on or after the lookback date.

The agency does not provide medical assistance coverage for institutionalized Individuals for the following services:

- Nursing facility services;
- Nursing facility level of care provided in a medical institution;
- Home and community-based services under a 1915(c) or (d) waiver.

Non-institutionalized individuals:

2.

The agency applies these provisions to the following noninstitutionalized eligibility groups. These groups can be no more restrictive than those set forth in section 1905(a) of the Social Security Act:

The agency withholds payment to non-institutionalized individuals for the following services:

- Home health services (section 1905(a)(7));
- Home & community care for functionally disabled elderly adults (section 1905(a)(22));
- Personal care services furnished to individuals who are not inpatients in certain medical institutions, as recognized under agency law and specified in section 1905(a)(24).

The following other long-term care services for which payment for medical assistance is otherwise made under the agency plan:

TN No. 09-012 Supersedes	Approval Date:	SEP 7 2010 Effective Da	te: 10/01/09
TN No. NEW			

#### STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

HAWAIL

State _____

#### TRANSFER OF ASSETS (cont.)

3,

Penalty Date-The beginning date of each penalty period imposed for an uncompensated transfer of assets is:

For individuals applying for Medicaid payment of long-term care services, the date on which the individual is eligible for medical assistance under the State plan and would otherwise be receiving institutional level of care services described in paragraph 1 that, were it not for the imposition of the penalty period, would be covered by Medicaid (based on an approved application for such care);

- OF
- For individuals receiving Medicaid payment for long-term care services, the first day of the month following timely advance notice of the penalty period.
- and
- Which does not occur during any other period of ineligibility for services by reason of a transfer of assets penalty.
- 4. Penalty Period Institutionalized Individuals

In determining the penalty for an institutionalized individual, the agency uses:

X The average monthly cost to a private patient of nursing facility services in the State at the time of application;

The average monthly cost to a private patient of nursing facility services in the community in which the individual is institutionalized at the time of application.

5. Penalty Period - Non-institutionalized Individuals

SEP

The agency imposes a penalty period determined by using the same method as is used for an institutionalized individual, including the use of the average monthly cost of nursing facility services:

Imposes a shorter penalty period than would be imposed for institutionalized individuals, as outlined below:

Approval Date:

7 2010 Effective Date:

10/01/09

#### STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State HAWAII

#### TRANSFER OF ASSETS (cont.)

- Penalty period for amounts of transfer less than cost of nursing facility care
  - X. Where the amount of the transfer is less than the monthly cost of nursing facility care, the agency imposes a penalty for less than a full month, based on the option selected in item 4.
  - X. The state adds together all transfers for less than fair market value made during the look-back period in more than one month and calculates a single period of ineligibility that begins on the earliest date that would otherwise apply if the transfer had been made in a single lump sum.
- Penalty periods transfer by a spouse that results in a penalty period for the individual
  - (a) The agency apportions any existing penalty period between the spouses using the method outlined below, provided the spouse is eligible for Medicaid. A penalty can be assessed against the spouse, and some portion of the penalty against the individual remains.

When both spouses are eligible for long-term care services, the State will use the following method to apportion the penalty period:

- Apportion the penalty period equally between the spouses;
- If one spouse dies or no longer requires long-term care services prior to the expiration of their share of the penalty period, the remainder of the penalty period will be assigned to the spouse who is still receiving long-term care services;
- The penalty months served by the institutionalized spouses shall not exceed the length of the original penalty period.
- If one spouse is no longer subject to a penalty, the remaining penalty period must be served by the remaining spouse.

(b)

6.

7.

#### STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State ____

HAWAII

#### TRANSFER OF ASSETS (cont.)

8.

#### Treatment of a transfer of income

When income has been transferred as a lump sum, the agency will calculate the penalty period on the lump sum value.

When a stream of income or the right to a stream of income has been transferred, the agency will impose a penalty period for each income payment.

For transfers of individual income payments, the agency will impose partial month penalty periods using the methodology selected in 6. above.

<u>X</u>

For transfers of the right to an income stream, the agency will bese the penalty period on the combined actuarial value of all payments transferred as described below.

The agency will consider the amount of income expected to be received during the individual's lifetime when the right to receive a stream of income was transferred. The total amount of income is calculated by multiplying the annual amount of income by the individual's life expectancy based on the life expectancy tables established by the Social Security Administration's Office of the Actuary.

9.

Imposition of a penalty for an undue hardship

The agency does not impose a penalty for transferring assets for less than fair market value in any case in which the agency determines that such imposition would deprive the individual of:

- (a) Medical care such that the individual's health or life would be endangered; or
- (b) Food, clothing, shelter, or other necessities of life.

10/01/09

#### STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State HAWAII

#### TRANSFER OF ASSETS (cont.)

10.

11.

Procedures for Undue Hardship Waivers

The agency has established a process under which hardship waivers may be requested that provides for:

- (a) Notice to a recipient subject to a penalty that an undue hardship exception exists;
- (b) A timely process for determining whether an undue hardship waiver will be granted; and
- (c) A process, which is described in the notice, under which an adverse determination can be appealed.

The procedures shall permit the facility in which the institutionalized individual is residing to file an undue hardship waiver application on behalf of the individual with the consent of the individual or the individual's personal representative.

Bed Hold Walvers for Hardship Applicants

The agency provides that while an application for an undue hardship waiver is pending in the case of an individual who is a resident of a nursing facility:

Payments to the nursing facility to hold the bed for the individual will be made for a period not to exceed ______ days (may not be greater than 30).

TN No.	09-012	ಕ ್ವೇ ಕ	050 7 2010	
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STATE FLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: HAWAII

The agency does not apply the trust provisions in any case in which the agency determines that such application would work an undue hardship.

The following criteria will be used to determine whether the agency will not count assets transferred because doing so would work an undue hardship:

- a) The maximum distribution from the trust in addition to other available income and assets of the individual is less than the State's eligibility standards for income and resources; or
- b) There are legal actions that prevent the distributions of funds to the medical and basic needs of the individual; and
- c) The individual has taken legal action to recover the funds placed in trust.

Under the agency's undue hardship provisions, the agency exempts the funds in an irrevocable burial trust.

The maximum value of the exemption for an irrevocable burial trust is

#### STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

#### State: Hawaii

#### METHODS FOR TREATMENT OF RESOURCES THAT ARE MORE LIBERAL THAN SSI

The following more liberal methods apply to all medical assistance groups except recipients of AFDC and SSI and persons deemed, for purposes of Title XIX, to be receiving AFDC or SSI. Deemed AFDC recipients are defined in item A.2, on pages 1 and 2 of Attachment 2.2-A of the Hawaii State Plan (also see 42 C.F.R. 435.115). Deemed SSI recipients include persons eligible under 42 C.F.R. 435.135 (the Pickle amendment); persons receiving SSI under section 1619(a) of the Act or considered to be receiving SSI under section 1619(b) of the Act; disabled widow(er)s eligible for Medicaid under section 1634(b) of the Act; disabled children eligible under section 1634(c) of the Act; and early aged widow(er)s eligible under section 1634(d) of the Act.

1. Basic maintenance items essential to day-to-day living such as clothing, furniture, stove, etc., shall be disregarded without regard to the value of the items.

TN No. 90-8 Supersedes Approval Date 11/12/90 Effective Date 7/1/90 TN No. HCFA ID: 4093E/0002P ¢,

Revision: HCFA-PM-97-2 December 1997 SUPPLEMENT NO TO ATTACHMENT 2.6-A Page 1 OMB No.:0938-0673

### STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: HAWAII

VARIATIONS FROM THE BASIC PERSONAL NEEDS ALLOWANCE

NONE

TN No. 98-003 Supersedes TN No

Approval Date 12/ 11/98

Effective Date 10/1 /98

SUPPLEMENT 13 TO ATTACHMENT 2.6-A Page 1

#### STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

#### State: <u>HAWAII</u>

#### SECTION 1924 PROVISIONS

- A. Income and resource eligibility policies used to determine eligibility for institutionalized individuals who have spouses living in the community are consistent with Section 1924.
- B. In the determination of resource eligibility the State resource standard is the maximum allowed by federal statute or regulations with provisions for increase, as allowed by the Secretary of Health and Human Services by means of indexing court order or fair hearing.
- C. An institutionalized spouse who (or whose spouse) has excess resources shall not be found ineligible under title XIX of the Social Security Act, per Section 1924(c)(3)(C), where the State determines that denial of eligibility on the basis of having excess resources would work an undue hardship.

TN No.. 90-16<br/>Supersedes<br/>TN No. 89-10Approval Date 3/1/91Effective Date 10/1/90

#### **Revision:**

#### SUPPLEMENT 16 TO ATTACHMENT 2.6-A Page 1

#### STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Hawaii

#### ASSET VERIFICATION SYSTEM

1940(a)

1.

The Agency will provide for the verification of assets for purposes of determining or redetermining Medicaid eligibility for aged, blind and disabled Medicaid applicants and recipients using an Asset Verification System (AVS) that meets the following minimum requirements:

- A. The request and response system must be electronic:
  - (1) Verification inquiries must be sent electronically via the internet or similar means from the Agency to the financial institution (FI).
  - (2) The system cannot be based on mailing paper-based requests.
  - (3) The system must have the capability to accept responses electronically.
- B. The system must be secure, based on a recognized industry standard of security (e.g., as defined by the U.S. Commerce Department's National Institute of Standards and Technology, or NIST).
- C. The system must establish and maintain a database of FIs that participate in the Agency's AVS.
- D. Verification requests also must be sent to FIs other than those identified by applicants and recipients, based on some logic such as geographic proximity to the applicant's home address, or other reasonable factors whenever the Agency determines that such requests are needed to determine or redetermine the individual's eligibility.
- E. The verification requests must include a request for information on both open and closed accounts, going back up to 5 years.

#### **Revision:**

# SUPPLEMENT 16 TO ATTACHMENT 2.6-A Page 2

#### STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Hawaii

#### ASSET VERIFICATION SYSTEM

requirements in Section 1.

2. System Development

Α.		The Agency itself will build and maintain an AVS.
		In 3 below, describe how the system will meet the requirements in Section 1.
8.	<u> </u>	The Agency will hire a contractor to build and maintain an AVS.
		In 3 below, identify the contractor, if known, and describe how the system will meet the requirements in Section 1.
C.		The Agency will be joining a consortium to develop an AVS.
		In 3 below, identify the States participating in the consortium. Also identify the contractor, if known, who will build and maintain the consortium's AVS, and how the system will meet the requirements in Section 1.
D		The Agency already has a system in place that meets the requirements for an acceptable AVS:
		In 3 below, describe how the system meets the requirements in Section 1.
E		Other alternative not included in A D. above.
		In 3 below, describe this alternative approach how it will meet the

**Revision:** 

## SUPPLEMENT 16 TO ATTACHMENT 2.6-A Page 3

#### STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Hawaii

#### ASSET VERIFICATION SYSTEM

3. Provide the AVS implementation description and other information requested for the implementation approach checked in Section 2.

A Request For Proposal (RFP) shall be issued to solicit participation by qualified contractors to design, develop, implement and operationalize an Asset Verification System (AVS) for purposes of determining Medicaid eligibility for aged, blind, and disabled Medicaid applicants and recipients as required under 1940 of the Social Security Act.

The AVS shall meet the requirements in Section 1 of Supplement 16 to attachment 2.6-A of the State Plan securing authorization from the applicant or recipient (and such other person, as applicable) at no cost.

The contractor shall provide the State with data reports; such as, but not limited to the following:

- a. Number of verification requests;
- b. Number of responses provided;
- c. Amount of undisclosed assets discovered; and
- d. Any other data reports necessary to meet federal reporting requirements.

#### STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

#### State HAWAII

#### DISQUALIFICATION FOR LONG-TERM CARE ASSISTANCE FOR INDIVIDUALS WITH SUBSTANTIAL HOME EQUITY

1917(f)

The State agency denies reimbursement for nursing facility services and other long-term care services covered under the State Plan for an individual who does not have a spouse, child under 21, or adult disabled child residing in the individual's home, when the individual's equity interest in the home exceeds the following amount:

\$600,000	(increased by the annual percentage increase in the urban
	component of the consumer price index beginning with 2011,
	rounded to the nearest \$1,000).

An amount that exceeds \$500,000 but does not exceed \$750,000 (increased by the annual percentage increase in urban component of the consumer price index beginning with 2011, rounded to the nearest \$1,000).

The amount chosen by the State is \$750,000

 X
 This higher standard applies statewide.

 This higher standard does not apply statewide. It only applies in the following areas of the State:

 X
 This higher standard applies to all eligibility groups.

This higher standard only applies to the following eligibility groups:

The State has a process under which this limitation will be walved in cases of undue hardship.

TN No. 09-011		OCD	1 2010	
Supersedes	Approval Date:	SEP	1 2010 Effective Date:	10/01/09
TN No. NEW				

#### STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

#### State: HAWAII

#### METHODOLOGY FOR IDENTIFICATION OF APPLICABLE FMAP RATES

The State will determine the appropriate FMAP rate for expenditures for individuals enrolled in the adult group described in 42 CFR 435.119 and receiving benefits in accordance with 42 CFR Part 440 Subpart C. The adult group FMAP methodology consists of two parts: an individual-based determination related to enrolled individuals, and as applicable, appropriate population-based adjustments.

#### Part 1 - Adult Group Individual Income-Based Determinations

For individuals eligible in the adult group, the state will make an individual incomebased determination for purposes of the adult group FMAP methodology by comparing individual income to the relevant converted income eligibility standards in effect on December 1, 2009, and included in the MAGI Conversion Plan (Part 2) approved by CMS on 03/31/2014. In general, and subject to any adjustments described in this SPA, under the adult group FMAP methodology, the expenditures of individuals with incomes below the relevant converted income standards for the applicable subgroup are considered as those for which the newly eligible FMAP is not available. The relevant MAGI-converted standards for each population group in the new adult group are described in Table 1.

TN No.	14-002				01 (01 (001 4
Supersedes		Approval Date:	05/16/2014	Effective Date:	01/01/2014
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Activity income f: f: f: f: f: f: f: f: f: f: f: f: f:	Covered Populations Within New Adult Group			Applicable	Population Adjustment	istment	
the indicate if the population adjustment will apply to each indicate if the population adjustment will apply to each population group. Provide additional information in corresponding attachments.	Relevant Population Group Standard For each population group, indicate the lower of:	о просоще	Resource Proxy	Enrollment Cap		8	Other Ađjustments
Mot         C         D         M           GI         C         D         M           GI         No         No         No           Zoff         No         No         No           Zoff         No         No         No           Zoff         No         No         No           Y         No         No         No           Y         No         No         No           Y         No         No         No           Y         No         Yes         No	<ul> <li>The reference in the MAGI</li> <li>Conversion Plan (Part 2) to conversion income standard and appropriate cross-reference,</li> <li>133% FPL.</li> </ul>	to the and the ce, or	nter "Y" (Ye ndicate if t opulation gr orresponding	s), "N" (No) he population oup. Provide attachments	or "NA" in the adjustment will additional infor	uppropriat apply to lation in	luma
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	NEW		c				

Supplement 18 to Attachment 2.6-A Page 2

1

#### Part 2 - Population-based Adjustments to the Newly Eligible Population Based on Resource Test, Enrollment Cap or Special Circumstances

- A. Optional Resource Criteria Proxy Adjustment (42 CFR 433.206(d))
  - 1. The state:
    - Applies a resource proxy adjustment to a population group(s) that was subject to a resource test that was applicable on December 1, 2009.
    - Does NOT apply a resource proxy adjustment (Skip items 2 through 3 and go to Section B)

Table 1 indicates the group or groups for which the state applies a resource proxy adjustment to the expenditures applicable for individuals eligible and enrolled under 42 CFR 435.119. A resource proxy adjustment is only permitted for a population group(s) that was subject to a resource test that was applicable on December 1, 2009.

The effective date(s) for application of the resource proxy adjustment is specified and described in Attachment B.

2. Data source used for resource proxy adjustments:

The state:

- Applies existing state data from periods before January 1, 2014.
- Applies data obtained through a post-eligibility statistically valid sample of individuals.

Data used in resource proxy adjustments is described in Attachment B.

- 3. Resource Proxy Methodology: Attachment B describes the sampling approach or other methodology used for calculating the adjustment.
- B. Enrollment Cap Adjustment (42 CFR 433.206(e))
  - 1.
- An enrollment cap adjustment is applied (complete items 2 through 4).
- An enrollment cap adjustment is not applied (skip items 2 through 4 and go to Section C).

TN NO.	14-002				
Supersedes		Approval Date:	05/16/2014	Effective Date:	01/01/2014
TN No.	NEW				

Supplement 18 to Attachment 2.6-A Page 4

- 2. Attachment C describes any enrollment caps authorized in section 1115 demonstrations as of December 1, 2009 that are applicable to populations that the state covers in the eligibility group described at 42 CFR 435.119 and received full benefits, benchmark benefits, or benchmark equivalent benefits as determined by CMS. The enrollment cap or caps are as specified in the applicable section 1115 demonstration special terms and conditions as confirmed by CMS, or in alternative authorized cap or caps as confirmed by CMS. Attach CMS correspondence confirming the applicable enrollment cap(s).
- 3. The state applies a combined enrollment cap adjustment for purposes of claiming FMAP in the adult group:
  - Yes. The combined enrollment cap adjustment is described in Attachment C.
  - No.
- 4. Enrollment Cap Methodology: Attachment C describes the methodology for calculating the enrollment cap adjustment, including the use of combined enrollment caps, if applicable.
- C. Special Circumstances (42 CFR 433.206(g)) and Other Adjustments to the Adult Group FMAP Methodology
  - 1. The state:
    - Applies special circumstances adjustment(s).
    - Does not apply a special circumstances adjustment.
  - 2. The state:
    - Applies additional adjustment(s) to the adult group FMAP methodology (complete item 3).
    - Does not apply any additional adjustment(s) to the adult group FMAP methodology (skip item 3 and go to Part 3).
  - 3. Attachment D describes the special circumstances and other proxy adjustment(s) that are applied, including the population groups to which the adjustments apply and the methodology for calculating the adjustments.

Supplement 18 to Attachment 2.6-A Page 5

Part 3 - One-Time Transitions of Previously Covered Populations into the New Adult Group

- A. Transitioning Previous Section 1115 and State Plan Populations to the New Adult Group
  - ☑ Individuals previously eligible for Medicaid coverage through a section 1115 demonstration program or a mandatory or optional state plan eligibility category will be transitioned to the new adult group described in 42 CFR 435.119 in accordance with a CMS-approved transition plan and/or a section 1902(e) (14) (A) waiver. For purposes of claiming federal funding at the appropriate FMAP for the populations transitioned to new adult group, the adult group FMAP methodology is applied pursuant to and as described in Attachment E, and where applicable, is subject to any special circumstances or other adjustments described in Attachment D.
  - The state does not have any relevant populations requiring such transitions.

### Part 4 - Applicability of Special FMAP Rates

A. Expansion State Designation

The state:

- Does NOT meet the definition of expansion state in 42 CFR 433.204(b). (Skip section B and go to Part 5)
- Meets the definition of expansion state as defined in 42 CFR 433.204(b), determined in accordance with the CMS letter confirming expansion state status, dated <u>1/23/2014</u>.
- B. Qualification for Temporary 2.2 Percentage Point Increase in FMAP.

The state:

- Does <u>NOT</u> qualify for temporary 2.2 percentage point increase in FMAP under 42 CFR 433.10(c)(7).
- Qualifies for temporary 2.2 percentage point increase in FMAP under 42 CFR 433.10(c)(7), determined in accordance with the CMS letter confirming eligibility for the temporary FMAP increase, dated (insert date). The state will not claim any federal funding for individuals determined eligible under 42 CFR 435.119 at the FMAP rate described in 42 CFR 433.10(c)(6).

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#### Part 5 - State Attestations

The State attests to the following:

- A. The application of the adult group FMAP methodology will not affect the timing or approval of any individual's eligibility for Medicaid.
- B. The application of the adult group FMAP methodology will not be biased in such a manner as to inappropriately establish the numbers of, or medical assistance expenditures for, individuals determined to be newly or not newly eligible.

#### ATTACHMENTS

Not all of the attachments indicated below will apply to all states; some attachments may describe methodologies for multiple population groups within the new adult group. Indicate those of the following attachments which are included with this SPA:

- Attachment A Conversion Plan Standards Referenced in Table 1
- Attachment B Resource Criteria Proxy Methodology
- Attachment C Enrollment Cap Methodology
- Attachment D Special Circumstances Adjustment and Other Adjustments to the Adult Group FMAP Methodology
- Attachment E Transition Methodologies

#### PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 4 hours per response, including the time to review instructions, searching existing data resources, gather data needed, and completed and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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Attachment A Page 1

Most Recent Updated Summary Information for Part 2 of Modified Adjusted Gross Income (MAGI) Conversion Plan*

02/28/2014

HAWAII

ABCDRFConversion for TWD Claining PurposeConversion for TPart 1 of approvedFPrevail of the function for the function fo		Fopulation Group	Net standard as of 12/1/09	Converted standard for FWAP claiming	Same as converted eligibility standard? (Yes, no, or n/a)	Source of information in Column C (New SIPP Conversion or Part 1 of approved state MAGI conversion plan)	Data source for Conversion (SIPP or state data)
100%     100%     100%     Yes     Part 1 of approved state MAGI conversion plan       100%     100%     100%     n/a     new SIPP conversion       100%     100%     n/a     new SIPP conversion       100%     100%     n/a     n/a       100%     100%     yes     part 1 of approved State MAGI	CALCULA	A	д	υ	A	M	ßa,
Parente/Carretaker Relatives100%100%100%Part 1 of approved state MGIFPL %Part 1 of approvedPart 1 of approvedPoroinstitutionalized DisabledNon-institutionalized DisabledNon-institutionalized DisabledPersonaNon-institutionalized DisabledNon-institutionalized DisabledPersonaNon-institutionalized DisabledNon-institutionalized DisabledPersonaNon-institutionalized DisabledNon-institutionalized DisabledPersonaNon-institutionalized Disabled PersonaNon-institutionalized DisabledPersonaNon-institutionalized Disabled PersonaNon-institutionalized Disabled PersonaPersonaNon-institutionalized Disabled PersonaNon-institutionalized DisabledPersonaNon-institutionalized Disabled PersonaNon-institutionalized DisabledPersonaNon-institutionalized Disabled PersonaNon-institutionalized Disabled	U U U	versions for FMAP Claiming Purposes					
Non-institutionalized DisbledNon-institutionalized DisbledPErsonsProversionFPL %100%Institutionalized Disbled Persons100%Institutionalized Disbled Persons100%PPL %n/aPPL %n/aInstitutionalized Disbled Persons100%Institutionalized Disbled Persons100%PPL %n/aChildren Age 19-20n/aIndex Aduitsn/aChildres Aduits100%PDL %100%PDL %Person plan	-	Parents/Caretaker Relatives FPL %	100%	100\$	Yes	Part 1 of approved state MAGI conversion plan	SIPP
Institutionalized Disabled Persons $100$ % $100$ % $n/a$ new SIPP conversion $FPL$ % $n/a$ $n/a$ $n/a$ $new SIPP conversionChildren Age 19-20n/an/an/an/aChildren Age 19-20n/an/an/an/aChildren Age 19-20n/an/an/an/aChildren Age 19-20n/an/an/an/aChildren Age 19-20n/an/an/aFPL %n/an/an/aFPL %100%100%100%FPL %m/am/am/a$	7	Won-institutionalized Disabled Persons FPL %	100%	100%	n/a	new SIPP conversion	Ad IS
Children Age 19-20     n/a     n/a       n/a     n/a     n/a       Childless Adults     100%     100%       FPL %     Yes     State MAGI       FPL %     conversion plan	m	Institutionalized Disabled Persons FPL &	100%	100%	n/a	new SIPP conversion	SIPP
Childless AdultsChildless Adults100%100%FPL %yesFPL %conversion plan	4	Children Age 19-20	n/a	n/a		n/a	n/a
	ъ	Childless Adults FPL %	100%	100\$	yes	Part 1 of approved State MAGI conversion plan	SIPP

n/a: Not applicable.

*The numbers in this summary chart will be updated automatically in the case of modification in the CMS approved MAGI conversion plan.

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Methodology For Identification For Applicable FMAP Rates. Refer to the January 23, 2014 correspondence between the State and CMS confirming the FMAP rates for our adult population, confirmation of expansion state status, and the enrollment cap for childless adults.

The federal medical assistance percentages (FMAP) percentages for individuals in the Adults Group shall be determined as follows:

- Monthly capitation payment files (RP 250) are produced by the 5th working day of each month. The monthly files contain payment and member month information for those enrolled during that month and retroactive payments from any previous month.
- 2) On 12/1/09 the baseline enrollment for the childless adults was 27,265. To calculate the percentage of expenditures that should be charged to the newly eligible populations (100% FMAP) Hawaii will extract all members with Eligibility Code (elg cd) equal to "A42". Code A42 is assigned by the eligibility system as childless adults with a FPL not to exceed 100%.
- 3) A count of member months will be totaled for each month during the quarter. A member month is defined as any member enrolled for any period during that month. If a member is enrolled during a partial month it is counted as one member month.
- 4) The following are examples of how calculations will be completed.

Expenditures for the childless adult population will include capitation payments and non-capitation payments including transplant services, behavioral health services, and fee for service payments not included in the capitation rates.

January 2014-25,000 February 2014-26,000 March 2014-27,000

Avg. Member Months for QTE 3/31/14-78,000/3=26,000

27265/26000=105% but capped at 100%

Expenditures-\$50,000,000

\$50,000,000 or 100% of the expenditures for childless adults will be charged to the transitional FMAP rate of 75.93%

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April 2014-30,000 May 2014-35,000 June 2014-40,000

Avg. Member Months for QTE 6/30/14-105,000/3=35,000

27,265/35000=77.9%

Expenditures \$60,000,000

46,740,000 or 77.9% of the expenditures will be charged to the newly eligible group at the transitional FMAP rate of 75.93% and \$13,260,000 or 22.10% will be charged to the newly eligible population at 100% FMAP.

5) The quarterly average member month data and baseline number will be submitted to CMS by the first of each month following the end of the quarter to load into the MBES system. The information will be emailed to CMS Central Office and to CMS Regional Office.

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## Hawaii QUEST Expanded Medicaid - Demonstration Transition Plan Addendum

#### A. Coverage in 2014

- The state does not intend to make any reductions to state plan eligibility for January 1, 2014. State plan beneficiaries will not have to take any action outside of the standard redetermination process.
- 2. The state will be delaying redetermination through March 31, 2014.
- 3. The state will transfer approximately 30,000-40,000 adults below 138 percent of federal poverty level (FPL) from the demonstration into the new adult group. This transition will require no action on the part of the beneficiary outside of the standard redetermination process.

#### B. Process for Transition

- Per the approved demonstration, Hawaii expanded coverage effective October 1, 2013. The January 1, 2014 transition of demonstration beneficiaries to the Medicaid state plan will be seamless from the perspective of the beneficiary.
- 2. The state's new eligibility and enrollment system went live on October 1, 2013. During the last week of September, the state conducted a mass conversion of data from the old system to the new system. This involved a crosswalk between the systems, migration of the data, and then a conversion to the new coding.
- 3. The state is currently using prepopulated renewal forms and will continue to use them in the future.
- 4. The state will collect the additional information necessary for a Modified Adjusted Gross Income (MAGI) determination at the beneficiary's redetermination, beginning April 2014.
- 5. Hawaii checks an individual for all Medicaid eligibility categories prior to terminating the individual from the Medicaid or demonstration program.

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6. Hawaii operates a State-based Marketplace (SBM). The Medicaid and SBM are separate entities. All applications for financial assistance are sent first to the Medicaid program, where individuals are screened for Medicaid eligibility. If the beneficiary is determined ineligible for Medicaid, the state will send all of the beneficiary's information electronically to the SBM. The SBM will then make an eligibility determination of for the Advanced Premium Tax Credit (APTC).

#### C. Notification Process/Notices

- 1. The state sent notices in both August and September 2013 to current beneficiaries informing them of the upcoming changes in eligibility and expansion program.
- 2. The state's Alternative Benefit Plan (ABP) has not yet been approved; however, Hawaii does not expect the approval of the ABP to result in any benefit changes for beneficiaries.
- 3. Hawaii does not intend to send any additional notices to beneficiaries moving from the demonstration to the state plan. Since this process will be seamless and not involve any change to benefits, the state feels that additional noticing would only create confusion about a process that will be seamless to the beneficiary.

#### D. Community Outreach

- The SBM received level II grants to help inform people about the Marketplace. The state is marketing its SBM and Medicaid program as a continuum of "help with health insurance".
- 2. The SBM has substantial outreach efforts to encourage people to apply. The SBM is working with navigators.
- 3. The state has advertisements in the community about the new healthcare options and expansion.

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Supersedes		Approval	Date:	05/16/2014	Effective Date:	01/01/2014
TN NO.	NEW			1		

SUPERSEDING PAGES OF STATE PLAN MATERIAL					
TRANSMITTAL NUMBER:	STATE:				
13-0007-MM5	Hawaii				
PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:	PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable):				
S88 Non-Financial Eligibility- State Residency	Section 2.3: Page 13, TN 87-4 Attachment 2.6-A: Page 3, TN 13-0007 MM6				

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# **Medicaid Eligibility**

OMB Control Number 0938-1148 OMB Expiration date: 10/31/2014

4.03	
tate	Residency
	he state provides Medicaid to otherwise eligible residents of the state, including residents who are absent from the state under ertain conditions.
I	ndividuals are considered to be residents of the state under the following conditions:
1	Non-institutionalized individuals age 21 and over, or under age 21, capable of indicating intent and who are emancipated or married, if the individual is living in the state and:
	Intends to reside in the state, including without a fixed address, or
	Entered the state with a job commitment or seeking employment, whether or not currently employed.
[	Individuals age 21 and over, not living in an institution, who are not capable of indicating intent, are residents of the state in which they live.
[	Non-institutionalized individuals under 21 not described above and non IV-E beneficiary children:
	Residing in the state, with or without a fixed address, or
	The state of residency of the parent or caretaker, in accordance with 42 CFR 435.403(h)(1), with whom the individual resides.
	Individuals living in institutions, as defined in 42 CFR 435.1010, including foster care homes, who became incapable of indicating intent before age 21 and individuals under age 21 who are not emancipated or married:
	Regardless of which state the individual resides, if the parent or guardian applying for Medicaid on the individual's behalf resides in the state, or
	Regardless of which state the individual resides, if the parent or guardian resides in the state at the time of the individual's placement, or
	If the individual applying for Medicaid on the individual's behalf resides in the state and the parental rights of the institutionalized individual's parent(s) were terminated and no guardian has been appointed and the individual is institutionalized in the state.
ł	Individuals living in institutions who became incapable of indicating intent at or after age 21, if physically present in the state, unless another state made the placement.
	Individuals who have been placed in an out-of-state institution, including foster care homes, by an agency of the state.
	Any other institutionalized individual age 21 or over when living in the state with the intent to reside there, and not placed in t institution by another state.
	IV-E eligible children living in the state, or



# **Medicaid Eligibility**

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Otherwise meet the requirements of 42 CFR 435.403.

TN No: 13-0007-MM5 Hawaii Approval Date: 09/26/2013 \$88-2

Effective Date: 1/1/2014

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# **Medicaid Eligibility**

Meet the criteria specified in an interstate agreement.

#### • Yes O No

The state has interstate agreements with the following selected states:

🔀 Alabama	🔀 Illinois	Montana	Rhode Island
X Alaska	🔀 Indiana	🛛 Nebraska	South Carolina
X Arizona	Iowa	Nevada	South Dakota
Arkansas	🗙 Kansas	New Hampshire	Tennessee
🛛 California	Kentucky	X New Jersey	Texas
Colorado	🛛 Louisiana	New Mexico	🔀 Utah
Connecticut	Maine	New York	Vermont
Delaware	Maryland	🔀 North Carolina	Virginia
District of Columbia	Massachusetts	🗙 North Dakota	Washington
Florida	X Michigan	🔀 Ohio	🛛 West Virginia
Georgia	Minnesota	🔀 Oklahoma	Wisconsin
🔀 Hawaii	🔀 Mississippi	Oregon	Wyoming
🔀 Idaho	. Missouri	Pennsylvania	

The interstate agreement contains a procedure for providing Medicaid to individuals pending resolution of their residency status and criteria for resolving disputed residency of individuals who (select all that apply):

Are IV-E eligible

Are in the state only for the purpose of attending school

Are out of the state only for the purpose of attending school

- Retain addresses in both states
- Other type of individual

The state has a policy related to individuals in the state only to attend school.

• Yes O No

Provide a description of the policy:

Medicaid eligibility is based upon the tax filing status of the individual. If the individual is claimed as dependent by an out-of-state tax filer, the individual is ineligible for medical assistance unless the individual provides additional evidence of residency.

Otherwise meet the criteria of resident, but who may be temporarily absent from the state.


- 24. P. Mer years - which

The state has a definition of temporary absence, including treatment of individuals who attend school in another state.

#### • Yes O No

Provide a description of the definition:

Medical assistance shall be provided to an individual temporarily absent from the state, which may include an individual attending school in another state and is claimed as a dependent by an in-state tax filer who:

(1) Meets all conditions of eligibility for medical assistance as specified in the department rules;

(2) Maintains Hawaii residency; and

(3) Requires medical services outside the State under circumstances where services were emergent or when it would be impractical to return to the State for the necessary services.

#### PRA Disclosure Statement

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SUPERSEDING PAGES OF STATE PLAN MATERIAL				
TRANSMITTAL NUMBER:	STATE :			
13-0007-MM6	Hawaii			
PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:	PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable):			
S89 Citizenship and Non-Citizenship Eligibility Template	Attachment 2.6-A: Page 2, item (3), paragraphs (a), (b), and (c), TN 09-003			
	Attachment 2.6-A: Page 3, item (3)(d), (e), and (f), TN 09-003			



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#### 1902(a)(46)(B) 8 U.S.C. 1611, 1612, 1613, and 1641 1903(v)(2),(3) and (4) 42 CFR 435.4 42 CFR 435.406 42 CFR 435.956

#### Citizenship and Non-Citizen Eligibility

The state provides Medicaid to citizens and nationals of the United States and certain non-citizens consistent with requirements of 42 CFR 435.406, including during a reasonable opportunity period pending verification of their citizenship, national status or satisfactory immigration status.

The state provides Medicaid eligibility to otherwise eligible individuals:

Who are citizens or nationals of the United States; and

Who are qualified non-citizens as defined in section 431 of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) (8 U.S.C. §1641), or whose eligibility is required by section 402(b) of PRWORA (8 U.S.C. §1612(b)) and is not prohibited by section 403 of PRWORA (8 U.S.C. §1613); and

Who have declared themselves to be citizens or nationals of the United States, or an individual having satisfactory immigration status, during a reasonable opportunity period pending verification of their citizenship, nationality or satisfactory immigration status consistent with requirements of 1903(x), 1137(d), 1902(ee) of the SSA and 42 CFR 435.406, and 956.

The reasonable opportunity period begins on and extends 90 days from the date the notice of reasonable opportunity is received by the individual.

The agency provides for an extension of the reasonable opportunity period if the individual is making a good faith effort to resolve any inconsistencies or obtain any necessary documentation, or the agency needs more time to complete the verification process.

• Yes O No

The agency begins to furnish benefits to otherwise eligible individuals during the reasonable opportunity period on a date earlier than the date the notice is received by the individual.

• Yes O No

The date benefits are furnished is:

• The date of application containing the declaration of citizenship or immigration status.

O The date the reasonable opportunity notice is sent.

Other date, as described:

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Hawaii



The state provides Medicaid coverage to all Qualified Non-Citizens whose eligibility is not prohibited by section 403 of PRWORA (8 U.S.C. §1613).

•Yes ONo

The state elects the option to provide Medicaid coverage to otherwise eligible individuals under 21 and pregnant women, lawfully residing in the United States, as provided in section 1903(v)(4) of the Act.

• Yes O No

Pregnant women

Individuals under age 21:

O Individuals under age 21

O Individuals under age 20

Individuals under age 19

An individual is considered to be lawfully residing in the United States if he or she is lawfully present and otherwise meets the eligibility requirements in the state plan.

An individual is considered to be lawfully present in the United States if he or she:

1. Is a qualified non-citizen as defined in 8 U.S.C. 1641(b) and (c);

2. Is a non-citizen in a valid nonimmigrant status, as defined in 8 U.S.C. 1101(a)(15) or otherwise under the immigration laws (as defined in 8 U.S.C. 1101(a)(17));

3. Is a non-citizen who has been paroled into the United States in accordance with 8 U.S.C. 1182(d)(5) for less than 1 year, except for an individual paroled for prosecution, for deferred inspection or pending removal proceedings;

4. Is a non-citizen who belongs to one of the following classes:

Granted temporary resident status in accordance with 8 U.S.C. 1160 or 1255a, respectively;

Granted Temporary Protected Status (TPS) in accordance with 8 U.S.C. §1254a, and individuals with pending applications for TPS who have been granted employment authorization;

Granted employment authorization under 8 CFR 274a.12(c);

Family Unity beneficiaries in accordance with section 301 of Pub. L. 101-649, as amended;

Under Deferred Enforced Departure (DED) in accordance with a decision made by the President;

Granted Deferred Action status;

Granted an administrative stay of removal under 8 CFR 241;

Beneficiary of approved visa petition who has a pending application for adjustment of status;

5. Is an individual with a pending application for asylum under 8 U.S.C. 1158, or for withholding of removal under 8 U.S.C. 1231, or under the Convention Against Torture who -

Has been granted employment authorization; or

Is under the age of 14 and has had an application pending for at least 180 days;



6. Has been granted withholding of removal under the Convention Against Torture:

7. Is a child who has a pending application for Special Immigrant Juvenile status as described in 8 U.S.C. 1101(a)(27)(J);

8. Is lawfully present in American Samoa under the immigration laws of American Samoa; or

- 9. Is a victim of severe trafficking in persons, in accordance with the Victims of Trafficking and Violence Protection Act of 2000, Pub. L. 106-386, as amended (22 U.S.C. 7105(b));
- 10. Exception: An individual with deferred action under the Department of Homeland Security's deferred action for the childhood arrivals process, as described in the Secretary of Homeland Security's June 15, 2012 memorandum, shall not be considered to be lawfully present with respect to any of the above categories in paragraphs (1) through (9) of this definition.

#### Other

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The state assures that it provides limited Medicaid services for treatment of an emergency medical condition, not related to an organ transplant procedure, as defined in 1903(v)(3) of the SSA and implemented at 42 CFR 440.255, to the following individuals who meet all Medicaid eligibility requirements, except documentation of citizenship or satisfactory immigration status and/or present an SSN:

Qualified non-citizens subject to the 5 year waiting period described in 8 U.S.C. 1613;

Non-qualified non-citizens, unless covered as a lawfully residing child or pregnant woman by the state under the option in accordance with 1903(v)(4) and implemented at 435.406(b).

#### PRA Disclosure Statement

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#### SUPERSEDING PAGES OF STATE PLAN MATERIAL

TRANSMITTAL NUMBER:

STATE :

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13-0007-MM1

Hawaii

Pages or sections of pages being superseded by S25, S28, S30, S51, S52, S53, S54, S55 and S14 and related pages or sections of pages being deleted as obsolete

State Plan Section	Complete Pages	Removed	Partial Pages Removed
	Page 1	1	Page 2, A.2.b
	Page 3		Page 2, A.2.c
	Page 3a		Page 2a, A.3
	Page 4		Page 9c, B.1 remove
	Page 4a		"Caretaker relatives"
Attachment 0 0 A	Page 12		and "Pregnant women"
Attachment 2.2-A	Page 13		Page 20, B.14
	Page 13a		Page 23c, B.19
	Page 14		Page 23c, B.22
	Page 14a		Page 25, C.4
	Page 21	12 July 1 - 1	
	Page 23		
	Page 23b		
Supplement 1 to Attachment 2.2-A	Page 1	a -	
	Page 3b		Page 1, A.2.a(i) and
	Page 11a		(iii) .
	Page 16		Page 6 related to AFD
	Page 19		recipients, pregnant
Attachment 2.6-A	Page 19a		women, infants, and
Attachment 2.6-A	Page 19b		children
	Page 21		Page 7, 1.a(1) and (2 Page 12, 5.e(2) and (3)
			Page 18, 5.e Page 25, 11.a(3)
Supplement 1 to Attachment 2.6-A	Pages 1-4		
Supplement 2 to Attachment 2.6-A	Pages 1-5		

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Supplement 5a to Attachment 2.6-A		Page 1, "Pregnant women and children - no limit on resources"
Supplement 8a to Attachment 2.6-A		Page 1, #1 Page 1, #2 delete citations for AFDC- related groups Page 2, delete citations for AFDC- related groups
Supplement 14 to Attachment 2.6-A	Page 1	
Supplement 15 to Attachment 2.6-A	Pages 1-3	



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Enter the AFDC Standards below. All states must enter:

MAGI-equivalent AFDC Payment Standard in Effect As of May 1, 1988 and AFDC Payment Standard in Effect As of July 16, 1996

Entry of other standards is optional.

The standard is as follows:

- Statewide standard
- O Standard varies by region
- O Standard varies by living arrangement
- O Standard varies in some other way



Effective Date: 1/01/2014

12.77



Household size	Standard (\$)	Additional incremental amount • Yes • No	a ta ta ta	
1	418	Increment amount \$ 146		
2	565	· · · · ·		
3	712			
4	859			
5	1,006			
6	1,153			
7	1,300			
8	1,446		t Marine	
9	1,593			
10	1,740			
11	1,740			
12	2,034			
13	2,181			
14	2,328			
15	2,475			

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O Standard varies by region

O Standard varies by living arrangement

O Standard varies in some other way

The dollar amounts increase automatically each year

O Yes O No

The standard is as follows:

- O Statewide standard
- O Standard varies by region
- O Standard varies by living arrangement
- O Standard varies in some other way

The dollar amounts increase automatically each year O Yes O No

The standard is as follows:

- O Statewide standard
- O Standard varies by region
- O Standard varies by living arrangement
- O Standard varies in some other way

The dollar amounts increase automatically each year

O Yes O No

TN No: 13-0007-MM1 Hawaii Approval Date: 09/13/2013 \$14-4 Effective Date: 1/01/2014

	Medicaid Eligibility	
-		r
	The standard is as follows:	
	O Statewide standard	
1	O Standard varies by region	
	O Standard varies by living arrangement	
	O Standard varies in some other way	
	The dollar amounts increase automatically each year	
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	The standard is as follows:	
	Ö Statewide standard	
10000	O Standard varies by region	
	O Standard varies by living arrangement	
	O Standard varies in some other way	
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	O Statewide standard	
	O Standard varies by region	
	O Standard varies by living arrangement	
	O Standard varies in some other way	
	The dollar amounts increase automatically each year	
1	O Yes O No	

TN No: 13-0007-MM1 Hawaii Approval Date: 09/13/2013 \$14-5

Effective Date: 1/01/2014



#### PRA Disclosure Statement

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10/31/2014

**S21** 

State Nan	ne: Hawa	aii	OMB Control Number: 0938-114
		er: 13 - 07 - 0000	Expiration date: 10/31/201
Presum	nptive E	Cligibility by Hospitals	S21
42 CFR 4	435.1110		
	-	fied hospitals are determining presumptive eligibiduals determined presumptively eligible under t	bility under 42 CFR 435.1110, and the state is providing Medicaid his provision.
• Yes	() No		
✓ The s	state attes	ts that presumptive eligibility by hospitals is adn	ninistered in accordance with the following provisions:
	A qualifie	d hospital is a hospital that:	
	its ele		an or a Medicaid 1115 Demonstration, notifies the Medicaid agency of tions and agrees to make presumptive eligibility determinations
	with a		failure to make presumptive eligibility determinations in accordance ilure to meet any standards that may have been established by the
	Assists ir	ndividuals in completing and submitting the full	application and understanding any documentation requirements.
	• Yes	○ No	
	The eligib	pility groups or populations for which hospitals d	etermine eligibility presumptively are:
	Pregn	nant Women	
	Infan	ts and Children under Age 19	
	Paren	nts and Other Caretaker Relatives	
	Adult	t Group, if covered by the state	
	Indiv	iduals above 133% FPL under Age 65, if covered	d by the state
	Indiv	iduals Eligible for Family Planning Services, if c	covered by the state
	Form	er Foster Care Children	
	Certa	in Individuals Needing Treatment for Breast or O	Cervical Cancer, if covered by the state
	Other	r Family/Adult groups:	
	🗌 Eligit	bility groups for individuals age 65 and over	
	🗌 Eligit	bility groups for individuals who are blind	
	🗌 Eligit	bility groups for individuals with disabilities	

Demonstration populations covered under section 1115



The state establishes standards for qualified hospitals making presumptive eligibility determinations.						
• Yes 🔿 No						
Select one or both:	Select one or both:					
The state has standards that relate to the proportion of individuals determined presumptively eligible who submit a regular application, as described at 42 CFR 435.907, before the end of the presumptive eligibility period.						
Description of standards:	<ul> <li>1. An 85% accuracy rate for correctly determined applications for HPE. This will be determined analyzing the HPE applications submitted by the hospital and evaluated for accuracy by EB staff 2. 90% of individuals are offered help from hospital PE staff to complete the full Medicaid application;</li> <li>3. 90% of hospital PE applicants will either submit a DHS 1100 application or an attestation sheets (completed by hospital staff for individuals who did not want to apply for regular Medicaid); and</li> <li>4. 90% of hospital PE application packets shall be submitted timely (within 5 days from submission of HPE application) by the participating hospital to Med-QUEST Eligibility Branch.</li> </ul>					
	at relate to the proportion of individuals who are determined eligible for Medicaid based on the on before the end of the presumptive eligibility period.					
The presumptive period begins	on the date the determination is made.					
The end date of the presumptive	e period is the earlier of:					
	termination for regular Medicaid is made, if an application for Medicaid is filed by the last day of nonth in which the determination of presumptive eligibility is made; or					
The last day of the month application for Medicaid is	following the month in which the determination of presumptive eligibility is made, if no s filed by that date.					
Periods of presumptive eligibili	ity are limited as follows:					
• No more than one period within a calendar year.						
○ No more than one period within two calendar years.						
No more than one period within a twelve-month period, starting with the effective date of the initial presumptive eligibility period.						
Other reasonable limitation:						
The state requires that a written application be signed by the applicant, parent or representative, as appropriate.						
	• Yes 🔿 No					
	lication form for Medicaid and presumptive eligibility, approved by CMS.					
• The state uses a separate ap included.	• The state uses a separate application form for presumptive eligibility, approved by CMS. A copy of the application form is included.					
	An attachment is submitted.					



The presumptive eligibility determination is based on the following factors:					
The individual's categorical or non-financial eligibility for the group for which the individual's presumptive eligibility is being determined (e.g., based on age, pregnancy status, status as a parent/caretaker relative, disability, or other requirements specified in the Medicaid state plan or a Medicaid 1115 demonstration for that group)					
Household income must not exceed the applicable income standard for the group for which the individual's presumptive eligibility is being determined, if an income standard is applicable for this group.					
State residency					
Citizenship, status as a national, or satisfactory immigration status					
$\overline{2}$ The state assures that it has communicated the requirements for qualified hospitals, and has provided adequate training to the hospitals. A copy of the training materials has been included.					
		An attachment is submitted.			

#### PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20140415



State of Hawaii Department of Human Services Med-QUEST Division

Please use this form to apply if you are a patient of the hospital, a patient's family member, or a community member.

#### **Application for Presumptive Eligibility for Medicaid**

Use this form to find out quickly if you qualify for presumptive eligibility for Medicaid. Presumptive eligibility offers you and your family immediate access to health care while you apply for regular Medicaid or other health coverage.

To find out if you qualify for regular Medicaid or other health coverage, you must complete the Hawaii Application for Health Coverage & Help Paying Costs. While you wait to learn if you qualify for regular Medicaid or other health coverage, you can get your health services through presumptive eligibility for Medicaid.

You can also apply for regular Medicaid and other health coverage online at mybenefit.hawaii.gov, via telephone, in person, or by mail.

<b>Who can</b>	<ul> <li>You can qualify for presumptive eligibility for Medicaid if you meet</li></ul>
qualify for	all of these rules: <li>Your income is below the applicable monthly limit.</li> <li>You are a U.S. citizen, U.S. national, or eligible non-citizen.</li> <li>You do not already have Medicaid.</li> <li>You have not had presumptive eligibility for Medicaid in the</li>
presumptive	past 12 months. <li>If you are pregnant, you have not had presumptive</li>
eligibility for	eligibility for Medicaid during this pregnancy. <li>You are in one of the groups that qualifies for presumptive</li>
Medicaid?	eligibility for Medicaid: <ul> <li>Children under 19 years of age</li> <li>Parents and caretaker relatives</li> <li>Pregnant women</li> <li>Other adults age 19 – 64 years</li> <li>People under age 26 who were in foster care</li> </ul>
How can I get help with this application?	Ask your hospital representative or call us toll free at 1-800-316- 8005. If you need help in a language other than English, call toll free at 1-800-316-8005 and tell the customer services representative the language you need. We will get you help at no cost to you. TTY/TTD users call toll free at 1-800-603-1201.

This is an important letter from the Department of Human Services. Please call the phone number located on the letter. When you call, you will be asked what language you speak and your call will be put on hold for an interpreter. You can also call 1-800-316-8005 for all DHS services.	English
這是一封從人類服務部門發出的重要信件。請撥打信上的電話號碼。當你打電話時,你將會被詢問你講什麼語言,您的通話 將被擱置直到接通翻譯服務。其他人類服務部門的服務, 您可以致電到 1-800-316-8005.	Cantonese *:
Ei taropwe mi auchchea seni ewe putain tumwunun aramas (Department of Human Services). Kose mwochen kokkori na nampan foon won na taropwe. Nupwen omw kokko, repwe eisinuk menni kkapas ke sine pwe repwe kkutta ngonuk emon choon chiaku. Ka pwan tongeni kokkori 1-800-316-8005 ren meinisin aninnis seni DHS.	Chuukese
Ceci est une lettre importante du Department of Human Services (DHS). S'il vous plaît, faire un appel téléphonique au numéro de téléphone situé sur la lettre. Lorsque vous téléphonez, quelqu'un va vous demander quelle langue vous parlez, et votre appel sera mis en attente pour un interprète. Vous pouvez aussi téléphoner 1-800-316-8005 pour tous les services de DHS.	French
Dies ist eon wichtiger Brief von der Abteilung Menschlicher Dienste (DHS). Bitte rufen Sie die Telefonnummer, die auf dem Brief gefunden wurde. Wenn Sie rufen, werden Sie gefragt werden, welche Sprache Sie sprechen, und Ihr Anruf wird auf Wartestellung für einen Dolmetscher geschaltet werden. Sie können 1-800-316-8005 für alle DHS Dienste auch rufen.	German
He leka ko'iko'i keia mai ka 'Oihana Lawelawe Kanaka (Department of Human Services). E kelepona mai i ka helu kelepona ma luna o ka leka. Ke kelepona 'oe, e ninau 'ia ana 'oe he aha kau 'olelo 'oiwi a laila e kali 'oe a loa'a ke kanaka mahele 'olelo. Hiki pu ia 'oe ke kelepona i 1-800-316-8005 no na lawelawe a pau a ka 'Oihana Lawelawe Kanaka (DHS).	Hawaiian
Daytoy ket importante nga surat nga naggapu iti Department of Human Services. Pangaasi nga tawagan yo iti numero iti telepono nga nakakabil iti daytoy nga surat. Nu umawag kayo, saludsuden da nu anya iti panagsasao yo ket urayen yo nga maiyallatiw iti tawag yo iti intepreter. Mabalin kayo nga umawayg iti 1-800-316-8005 para kadagiti amin nga serbisyo iti DHS.	llocano
ハワイ州人道的奉仕局からの大切なお知らせです。この紙面に書かれている番号にお電話ください。電話を された時 に、貴方がどの言語を話されているかを聞かれます、 通訳に接続 されるまでしばらくお待ち ください。 DHSのどの サービスにも、 この電話番号 1-800-316-8005 で対応いたします.	Japanese
인간 서비스 부서에서 보내는 중요한 편지 입니다. 이편지에 기재된 전화번호로 전화를 하시요. 당신이 전화를 할때 당신이 사용하는 언어를 물을것이고 그언어의 통역인에게 연결할것 입니다. 당신은 모든 인간 서비스 부서(디에이치에스)에 도움을 받기 위해서1-800-316-8005 로 전화 할수 있읍니다	Korean
这是一封从人类服务部门发出的重要信件。请拨打信上的电话号码。当你打电话时,你将会被询问你讲什 么语言, 您的通话将被搁置直到接通翻译服务。其他人类服务部门的服务, 您可以致电到 1-800-316-8005。	Mandarin ★
Juon in kojela im elap an aurok im ej itok jen ra eo an department of human services. Jouij im call e nomba in im ej bed ilo pepa in ak letta in. Ne koj call, renej kajitok ibbem kin kain kajin eo am im elikin am ba renej ba kwon kottar bwe ren lewoj juon am ri okok. Komaron call 1-800-316-8005 non aolepen ra ko kajojo ilo DHS services.	Marshallese
O se fa'asilasilaga ta'ua lenei mai le Ofisa o le Human Services. Fa'amolemole, vala'au mai i le numera lea o lo'o i luga o lenei tusi. A e vala'au mai, o le a fesili atu po'o le a le gagana e te mo'omia, ona tu'u sa'o lea o lau telefoni i se tagata e mafai ona fesoasoani ia oe. E mafai fo'i ona e vala'au i le number 1-800-316-8005 mo nisi 'au'aunaga mai lenei Ofisa."	Samoan C
Ésta es una carta importante de la Sección de Servicios Humanos (DHS). Por favor llame el número de teléfono localizado en la carta. Cuando usted llama, usted se preguntará qué idioma usted habla y su llamada se pondrá en espera para un intérprete. Usted también puede llamar 1-800-316-8005 para todos los servicios de DHS.	Spanish ::
Ito ay mahalaga na sulat na galling sa Department of Human Services. Mangyaring tawagan ang numero na nakalagay sa sulat na ito. Kung kayo ay tatawag , tatanungin kung ano ang iyong wika at hintayin ninyo hanggat may sumagot na tagasalin. Pwede ninyong tumawag sa 1-800-316-8005 para sa lahat ng serbisio sa	Tagalog
Ko e tohi mahu'inga eni mei he Potungaue Ngaue Ma'ae Kakai. Kataki 'o telefoni ki he fika 'oku ha 'i he tohi ni. 'E fehu'i atu pe ko e ha e fa'ahinga lea 'oku ke lea'aki 'i he taimi te ke ta mai ai pea tnitokoe ke tali kae 'oua kuo ma'u ha toko taha fakatonu lea. Te ke lava 'o ta ki he ki he ngaahi tokoni kotoa 'a e DHS.	Tongan +
Đây là lá thơ quang trọng từ các Bộ Phục Vụ Nhân Dân (DHS). Làm ơn gọi xố điện thoại nằm trên lá thơ. Khi bạn gọi, bạn sẻ được hỏi ngôn ngữ nào bạn nói và cú điện thoại của bạn sẻ chờ người thông dịch. Đồng thời bạn củng có thể gọi số 1- 800-316-8005 cho các phục vụ DHS.	Vietnamese Việt Nam
Kini importante nga sulat gikan sa Department of Human Services (DHS). Palihug tawagi ang numero sa maong telepono nga nahimutang sa sulat. Sa imong pagtawag, ikaw pangutan-on kun unsa ang imong pinulongan ug ang imong tawag ilang ipahulat para sa usa ka taghubad sa pinulongan. Mahimo usab nga imong tawagan ang 1-800- 316-8005 para sa tanang mga serbisyo sa DHS.	Visayan

### **STEP 1** Tell us about yourself.

We need one adult in the family to be the contact person for your application.

1. First Name	Middle name		Last name	Suffix
2. Home address (Leav	ve blank if you don't have one.	)		3. Apartment or suite number
4. City	4	5. State	6. ZIP code	7. County
8. Mailing address (if di	ifferent from home address)			9. Apartment or suite number
10. City		11. State	12. ZIP code	13. County
14. Phone number ( )			15. Other phone nu	umber
, 0	information about this applica		ail? 🗌 Yes 🗌 No	
17. What is your preferm	red spoken language (if not Er	nglish)?	18. What is your preferred	d written language (if not English)

### STEP 2

#### Tell us about your family.

List yourself and the members of your immediate family who live with you. Include your spouse, your children under the age of 19 years if they live with you and anyone you include on your tax return, even if they don't live with you.

Name (first, middle, last)	Date of birth (XX/XX/XXXX)	Relationship to you	Applying for presumptive eligibility for Medicaid? (Yes or No)	Already has Medicaid or other medical insurance? (Yes or No)	U.S. Citizen, U.S. National or eligible Non-citizen? (Yes or No)	Hawaii (Yes or No)	Social Security Number (SSN) (You don't have to provide this now, but it helps us determine eligibility for regular Medicaid faster)
							ying. If a person is not e questions for that
(Same as above)		(Self)					

## **STEP 3** Other questions.

Answer these questions for yourself and your family members listed in Step 2. out if you and any family member(s) qualify.	. Your answers will make it ea	sier to find
Is anyone pregnant who is applying for presumptive eligibility for Medicaid?	□ Yes	□ No
If yes, who?	How many babies does she expect?	
Is anyone who is applying for presumptive eligibility for Medicaid receiving Medicare or Social Secu	urity Income (SSI)?	□ No
If yes, who?		
Is anyone who is applying for presumptive eligibility for Medicaid a parent or caretaker relative? For example, a grandparent who is the main person taking care of a child.	□ Yes	□ No
If yes, who?		
Was anyone who is applying for presumptive eligibility for Medicaid in foster care at age 18?	□ Yes	□ No
If yes, who?		

## **STEP 4** Tell us about your family's income.

Write the total income before taxes are taken for all family members listed in Step 2.

• Job income: For example, wages, salaries, and self-employment income.					
Amount \$	How often? (check one) Ueekly Biweekly Monthly Yearly				
• Other income For example, unemployment checks, alimony, or disability payments from the Social Security Administration ("SSDI"). Do not include Supplemental Security Income ("SSI payments") or any child support you receive.					
Amount \$	How often? (check one) UWeekly Biweekly Monthly Yearly				

### **STEP 5** Read & sign this application.

- I'm signing this application under penalty of perjury which means I've provided true answers to all questions this form to the best of my knowledge. I know that I may be subject to penalties under state or federal law if I provide false or untrue information.
- I understand that under federal law, discrimination isn't permitted on the basis of race, color, national origin, sex, age, secual orientation, gender identity, or disability. I can file a compliant of discribination by visiting www.hhs.gov/ocr/office/file.
- The person who filled out Step 1 should sign this application.

Signature	Date (mm/dd/yyyy)

## **SIEP6** If you qualify for presumptive eligibility for Medicaid, what happens next?

- You will get a notice from the hospital saying you were approved.
- You can start using your presumptive eligibility for Medicaid coverage right away for Medicaid covered services such as doctor visits, hospital care, and some prescription drugs. You can go to any health care provider who accepts Medicaid starting the day you are approved. To start using your presumptive eligibility for Medicaid, use your approval notice from the hospital saying you are approved.
- To see if you qualify for regular Medicaid or other health coverage, the hospital will help you fill out the Hawaii Application for Health Coverage & Help Paying Costs, if you choose. You can also apply for regular Medicaid and other health coverage online at mybenefit.hawaii.gov, via telephone, in person, or by mail.
- Your presumptive eligibility will end on the date your application for Medicaid is either approved or denied. If you are denied, you will be referred to the Connector for other affordable insurance programs.
- If you do not fill out and submit the Hawaii Application for Health Coverage & Help Paying Costs to see if you qualify for regular Medicaid or other health coverage, your presumptive eligibility for Medicaid coverage will end on the last day of the month after the month you are approved.

For example, if you qualified for presumptive eligibility for Medicaid in January, it will end on the last day of February.

## **STEP 7** If you do not qualify for presumptive eligibility for Medicaid, what happens next?

You will get a notice from the hospital saying you were not approved. You cannot appeal the hospital's decision. But you can still apply for regular Medicaid or other health coverage using the Hawaii Application for Health Coverage & Help Paying Costs.

# Hospital Presumptive Eligibility in Hawaii

## **Overview**

- What is Hospital Presumptive Eligibility (HPE)?
- How hospitals can participate in HPE
- Hospital staff eligible to make HPE determinations
- Who is eligible and what are the HPE benefits?
- How the HPE Process works
- Contact information

## **ACA Coverage Changes**

The Affordable Care Act (ACA) was signed into law in March 2010; it makes major changes to how people secure health coverage in the U.S. Coverage changes include:

- Medicaid and CHIP expansion and improvements
- Health insurance marketplaces for individuals and small businesses
- Private insurance market reforms

## The New Vision for Medicaid and CHIP

#### Medicaid Coverage Expansion

 Covers adults 19-64 with incomes up to 133% FPL who are not eligible and enrolled in a mandatory group

#### Single, Streamlined Application

 Individuals can apply for Marketplace coverage and all insurance affordability programs (Medicaid, CHIP, premium tax credits) on one application

#### • Simplified Eligibility and Enrollment Rules

 Modified Adjusted Gross Income (MAGI) is the new income methodology based on IRSdefined concepts of income and household to determine Medicaid and CHIP eligibility for children, pregnant women, parents and caretaker relatives, and adults 19-64

#### Modernized Eligibility Systems

 Increases use of automated rules engines to enable real-time eligibility determinations; individuals can apply for coverage online

#### Children's Coverage Improvements

All children up to age 19 with family incomes up to 133% FPL are now Medicaid-eligible

#### Hospital Presumptive Eligibility

- Hospitals can now determine individuals to be presumptively eligible for Medicaid



# **HPE Overview**

# What Is Hospital Presumptive Eligibility (HPE)?

- As of January 1, 2014, hospitals can immediately determine Medicaid eligibility for certain individuals who are likely to be eligible.
- Eligibility under HPE is temporary but allows immediate access to coverage for eligible individuals.
- The policies and procedures for determining HPE may differ from the current policies and procedures for determining regular Medicaid assistance.



- **Application Signature**: The application must be signed by an adult household member (age 18 or over) or by an authorized representative.
- **Application Submission**: Applications may be submitted in person, by mail, or by fax.
- Certain Individuals Needing Treatment for Breast or Cervical Cancer: An individual who has been screened by an authorized CDC approved facility and requires treatment for breast or cervical cancer or a precancerous condition of the breast or cervix.
- **Dependent Child**: A child from birth to age 19
- Eligibility Determination: An approval or denial of eligibility.
- Family Size Using Modified Adjusted Gross Income (MAGI) Methodology: Means the number of persons counted as members of an individual's household. When determining the family size of individuals who have a pregnant woman in their household, the pregnant woman is counted just as herself.

TN NO: 13-007-MM7

- Former Foster Care Child: An individual who is 18 to 26 years of age, not eligible for any other Medicaid coverage group, and was covered under Medicaid and in foster care when they turned age 18 or out of foster care.
- Modified Adjusted Gross Income (MAGI): The methodology used to determine financial eligibility.
- Non-Applicant: An individual who is not seeking an eligibility determination for himself or herself and is included in an applicant's or client's household to determine eligibility for such applicant or client.
- Non-Filer: Individuals who do not intend either to file taxes or to be claimed as a tax dependent.

- **Parent/Caretaker Relative**: A relative of a dependent child by blood, adoption, or marriage with whom the child is living, who assumes primary responsibility for the child's care, and who is one of the following:
  - The child's father, mother, grandfather, grandmother, brother, sister, stepfather, stepmother, stepbrother, stepsister, uncle, aunt, first cousin, nephew, or niece;
  - The spouse of such parent or relative including same sex marriage, even after the marriage is terminated by death or divorce; or
  - Another relative of the child based on blood, adoption, or marriage; the domestic partner of the parent or caretaker relative; or an adult with whom the child is living and who assumes primary responsibility for the dependent child's care.

- Pregnant Woman Hospital Presumptive Eligibility: Medical coverage for an individual eligible in the Pregnant Women group is limited to prenatal services that are provided on an outpatient basis. For coverage of full Medicaid benefits, a pregnant woman must apply for regular Medicaid assistance.
- **Tax Dependent**: An individual for whom another individual claims a deduction for a personal exemption for a taxable year.
- **Tax Filer**: Individuals who intend to file a federal tax return for the coverage year and who do not intend to be claimed as a tax dependent by another taxpayer.



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Effective Date: January 1, 2014

## How HPE Works to Get People Connected to Coverage and Care

- HPE improves individuals' access to Medicaid and necessary services by providing another channel to apply for medical coverage.
- Hospitals will be reimbursed for services provided during the PE period.
- HPE is not about short-term coverage; it provides individuals with an opportunity to get connected to longer-term coverage options.



Approval Date November 18, 2015

# How Hospitals Can Participate in HPE

## **How Hospitals Can Participate in HPE**

- Hospital participation in HPE is <u>optional</u>, but States must provide a mechanism for a hospital to become qualified to offer the HPE program.
- To make HPE determinations, a hospital must:
  - Participate in the Medicaid program;
  - Notify the State of its election to make HPE determinations by contacting the Program Administrator;
  - Designated staff must complete HPE training modules;
  - Agree to make HPE determinations consistent with policies and procedures of the State by signing an attestation form;
  - Maintain performance standards set by State; and
  - Have a signed Memorandum of Agreement (MOA) with the Department on file.

## Hospital Staff Eligible to Make HPE Determinations

- Once a hospital is a qualified entity:
  - Any hospital employee who is properly trained and certified can make HPE determinations.
- Participating hospitals may not delegate HPE determinations to non-hospital staff:
  - Third party vendors or contractors may not make HPE determinations.
- Eligibility determinations will be based on MAGI non-filer rules:
  - The household's size will be determined by counting the individual plus their spouse and natural, adopted and step-children under age 19, or up to age 26 if a full time student, who are living together in the same household and who are not expected to be claimed by another tax-filer.



## **How Will Hospitals Be Trained?**

The Department will use a Medicaid training module consisting of:

- This powerpoint presentation, which provides an overview of the Hospital Presumptive Eligibility (HPE) program and application for full Medicaid requirements for participating hospital staff;
- HPE Workshop conducted by assigned DHS staff.

The Department will conduct additional training(s) to address hospital deficiencies after initial implementation of HPE :

- Department staff will monitor hospital ability to meet performance standards;
- Additional training will focus on areas that need improvement or additional guidance.


# Workshop and Training will include:

- Overview of HPE and regular Medicaid programs;
- Roles and responsibilities for the Hospital and Eligibility branch;
- Explanation of performance standards and requirements;
- Eligibility requirements for HPE, Children, Pregnant Women, Parent Caretaker Relatives, Adults, Former Foster Care Children and Certain Individuals Needing Treatment for Breast or Cervical Cancer * coverage groups;
- How to complete the HPE application form, DHS 1100, and other applicable Medicaid forms;
- The HPE eligibility determination process using MAGI non-filer rules for household composition and income eligibility;
- How to prepare and submit the HPE packet to EB for processing;
- All bases of coordination between hospital and Med-QUEST required to process for HPE (assigned staff, contact numbers, etc).
- * Hospital must be designated as a CDC approved screening site for BCCEDP

# Process for Staff Training and Certification

- Hospitals must select staff for training and certification and provide list of names for Department;
- Hospitals must coordinate with Med-QUEST to arrange for training of staff;
- Selected staff must attend Department approved HPE/Medicaid Workshop and Training;
- Staff must complete Department approved workshop and training and become certified in order to make HPE determinations;
- Staff must sign agreement to comply with all MOA requirements for participation in the HPE program;
- Certified hospital staff will be able to determine eligibility and issue notice of approval for HPE coverage to eligible individuals.

# HPE Accuracy and Performance Standards

Hospitals shall be required to maintain the following performance standards to participate in the HPE program:

- An 85% accuracy rate for correctly determined applications for HPE. This will be determined analyzing the HPE applications submitted by the hospital and evaluated for accuracy by EB staff;
- 2) 90% of individuals are offered help from hospital PE staff to complete the full Medicaid application;
- 3) 90% of hospital PE applicants will either submit a DHS 1100 application or an attestation sheets (completed by hospital staff for individuals who did not want to apply for regular Medicaid); and
- 4) 90% of hospital PE application packets shall be submitted timely (within 5 days from submission of HPE application) by the participating hospital to Med-QUEST Eligibility Branch.

# **HPE Performance Standards**

- The Department shall initially authorize a "Phase in " period to help hospitals reach required performance standards without penalty for initial 6-12 months of HPE program implementation.
- The Department shall analyze initial performance standards and focus training on areas that are not meeting requirements. Hospitals not meeting HPE program requirements will complete additional training in deficient areas. If still unable to meet standards after additional training, hospital will be subject to disqualification from the HPE program.
- The Department has the authority to terminate hospital participation in the HPE program for failure to meet Department policies and established standards, including failure to participate in additional training when deficiencies are identified.



Who is Eligible to Enroll in Medicaid through HPE? What are the Benefits?

# Populations Eligible for Medicaid via HPE Determinations

 Individuals who fall into one of the following MAGI groups may be determined for HPE:

Children, Pregnant Women, Parents and Caretaker relatives, Adults, Former Foster Care Children and Certain Individuals Certain Individuals Needing Treatment for Breast or Cervical Cancer who are:

- Not currently receiving Medicaid benefits and have not had a PE period in the last 12 months or for the same pregnancy (for a pregnant woman);
- A Hawaii resident; and
- A U.S. citizen or qualified non-citizen who meets Medicaid citizenship status requirements.

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# Criteria for Determining HPE Eligibility

The current MAGI rules are used to determine the following:

- Household Size;
- Coverage Group; and
- Financial Eligibility.
- The Department will use non-filer MAGI rules when determining financial eligibility for the HPE program.



## **HPE Income Eligibility Chart**

нн	Care	nts or taker tives		ults/ en 6-19		nildren < 6	-	nt Women/ Id < 1		:HIP en < 19
Size	100%	105%*	133%	138%*	139%	144%*	191%	196%*	308%	313%*
1	\$1,130	\$1,186	\$1,502	\$1,502	\$1,570	\$1,626	\$2,157	\$2,157	\$3,478	\$3,535
2	\$1,528	\$1,528	\$2,032	\$2,032	\$2,124	\$2,200	\$2,918	\$2,918	\$4,705	\$4,782
3	\$1,926	\$1,926	\$2,562	\$2,562	\$2,677	\$2,774	\$3,679	\$3,679	\$5,932	\$6,028
4	\$2,325	\$2,325	\$3,092	\$3,092	\$3,231	\$3,347	\$4,440	\$4,440	\$7,159	\$7,275
5	\$2,723	\$2,723	\$3,621	\$3,621	\$3,785	\$3,921	\$5,200	\$5,200	\$8,386	\$8,522
6	\$3,121	\$3,121	\$4,151	\$4,151	\$4,338	\$4,494	\$5,961	\$5,961	\$9,613	\$9,769
7	\$3,520	\$3,520	\$4,681	\$4,681	\$4,892	\$5,068	\$6,722	\$6,722	\$10,840	\$11,015
8	\$3,918	\$3,918	\$5,211	\$5,211	\$5,446	\$5,642	\$7,483	\$7,483	\$12,066	\$12,262
9	\$4,317	\$4,317	\$5,741	\$5,741	\$6,000	\$6,215	\$8,244	\$8,244	\$13,293	\$13,509
10	\$4,707	\$4,707	\$6,270	\$6,270	\$6,553	\$6,789	\$9,005	\$9,005	\$14,520	\$14,756
Each Add'l Person	\$399	\$419	\$530	\$550	\$554	\$574	\$761	\$781	\$1,227	\$1,247

### 2015 Standards of Assistance

* Maximum allowable income with 5% disregard applied to the income standard as applicable.

Note: 1) Former Foster Care Children have no income limit;

2) Financial eligibility for Certain Individuals Needing Treatment For Breast or Cervical Cancer is not subject to Medicaid income limits.

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## **Countable Income Includes:**

- Wages, salaries, tips, etc. ;
- Taxable interest;
- Alimony;
- Business income;
- Capital gains;
- Unemployment benefits;
- Rental real estate, royalties, partnerships, S corporations, etc. ;
- Other taxable income.

### *ASSETS ARE NOT COUNTED FOR THE MAGI ELIGIBILITY GROUPS

## **Non-Tax Filer MAGI rules**

Non-Tax filer MAGI rules will be used to determine financial eligibility for HPE applicants, regardless of their actual tax filing status. To determine household size, count the following household members:

- a. Applicant (and if living with the applicant):
  - Spouse
  - Child(ren)* under age 19 years
- b. If applicant is under age 19 (and if living with the applicant):
  - Spouse
  - Child(ren)* under age 19 years;
  - Parent(s)*
  - Sibling(s)* under age 19 years

*Includes natural or biological, adopted, or step (parent/child/sibling). For sibling, includes half- sibling.

## Determination of Household size, Income and Coverage Group

- Evan (age 29) is applying for coverage for himself, his pregnant wife, Keira (age 26), and their daughter, Lilly (age 3) who all live together. Evan states he earns \$1800 per month from his job. Keira does not work. Although Evan and Keira intend to file jointly, MAGI non-filer rules are applied to determine eligibility for HPE.
- 2) Evan and Keira have daughter Lily, so are first determined for eligibility under the Parent/Caretaker Group. If not eligible in this group, would be considered under another applicable coverage group (i.e. Adults).

Lilly is under age 6, therefore, she is determined for eligibility under the Childrens Group (Child 1<6).

## Determination of Household size, Income and Coverage Group (Cont'd)

- 3) Using the HPE Income Eligibility chart:
  - Evan and Keira's income of \$1,800 < \$1,926 Parent/Caretaker Group standard for a household size of 3, therefore, they are eligible under this coverage group.
  - Lilly's income of \$1,800 < \$2,677 Children Group standard for a household size of 3, therefore she is eligible under this group.
- 4) Tax household composition, size and coverage groups for Evan, Keira, & Lilly are shown below:

HH	Evan	Keira	Lilly	Family Size	Income	Coverage Group
Evan	Х	X	X	3	\$1,800	Parent/Caretaker
Keira	Х	X	X	3	\$1,800	Parent/Caretaker
Lilly	Х	Х	Х	3	\$ 1,800	Children

# What are the Benefits?

Individuals approved for presumptive eligibility receive the same Medicaid services as the group they are approved for under the Medicaid State Plan and 1115 Waiver as applicable. However, for individuals eligible in the Pregnant Women group, presumptive eligibility is limited to ambulatory prenatal care only.



# **Duration of Eligibility under HPE**

- The HPE period begins with, and includes, the day on which the hospital makes the HPE determination.
- The HPE period ends on:
  - The day on which the eligibility site makes the eligibility determination for full Medicaid; or
  - The last day of the month following the month in which the hospital makes the HPE determination if the individual did not apply for Medicaid.
- The HPE period is limited to one in a 12 month period and/or once per pregnancy for a pregnant woman.

# How The HPE Process Works

- The HPE application is a short application form for individuals to apply for hospital presumptive eligibility. It requests minimal information such as:
  - Contact information
  - Household members
  - Total income for the household
- For individuals with no previous Medicaid ID number, a temporary ID number will be created using the hospital's provider ID + the last 4 digits of the individual's SSN until a Medicaid ID number is generated by Med-QUEST staff;
- Hospital shall log all HPE applications and send monthly data to Med-QUEST for monitoring purposes.

# **Verification of Eligibility Criteria**

- Hospital Presumptive Eligibility determinations will be based on selfattestation of required information;
- Individual cannot be required to provide proof/documentation of any HPE eligibility criteria (e.g., can't require medical verification of pregnancy);
- Hospital/Department must accept self-attestation of income, citizenship/immigration status, State residency and household size.



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# **The HPE Determination Process**

At the individual's initial visit, trained hospital staff shall:

- Check for current Medicaid eligibility by contacting the Enrollment Call Center for applicable information (Medicaid status, Medicaid ID number, Health plan);
- If already a Medicaid recipient, refer applicant to appropriate health plan for assistance, not eligible for HPE;
- If not a Medicaid recipient, determine if individual meets HPE eligibility requirements for appropriate coverage group;
- Self-attestation of previous or current Medicaid eligibility shall be accepted during non-business hours;
- If HPE requirements are met, help the individual complete the HPE application form for HPE. If determined ineligible for HPE, explain benefits of "regular" Medicaid and offer to help applicant complete the DHS 1100, "Application for Health Coverage & Help Paying Costs" form for submission to Med-QUEST if interested in applying;

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# The HPE Determination Process (cont'd)

- Complete HPE eligibility determination and give applicant approval notice verifying applicant's HPE eligibility, coverage group and effective date of HPE coverage;
- Explain to applicant that the notice will serve as verification of eligibility for applicant;
- Offer assistance to applicant to apply for regular Medicaid by completing the DHS 1100 form.
- If applicant chooses <u>not</u> to apply for Medicaid, indicate this on the "Attestation sheet for DHS 1100" and sign in the field indicated on the bottom of the sheet.
- If applicant wants to apply for regular Medicaid, assist with application form and have HPE applicant sign and date the "Attestation sheet for DHS 1100"; and
- Submit with the HPE packet to the EB unit.

# Create HPE packet to send to Med-QUEST

Upon completion of the HPE determination, hospital staff shall:

1) Create HPE packet to fax to appropriate EB office consisting of:

- Completed and signed HPE packet cover sheet;
- Completed HPE application
- HPE decision notice;
- Completed DHS 1100 if applicable; and
- Completed Attestation sheet for DHS 1100
- 2) Record HPE application on hospital HPE log and date information is faxed to EB;
- Fax complete packet to the appropriate Med-QUEST office within 5 days for HPMMIS input and determination of regular Medicaid; and
- 4) Keep hard copies of HPE packets for future reference.

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 State of Hawaii
 Please use

 Department of Human Services
 of the hospi

 Med-QUEST Division
 community

Please use this form to apply if you are a patient of the hospital, a patient's family member, or a community member.

### Application for Presumptive Eligibility for Medicaid

Use this form to find out quickly if you qualify for presumptive eligibility for Medicaid. Presumptive eligibility offers you and your family immediate access to health care while you apply for regular Medicaid or other health coverage.

To find out if you qualify for regular Medicaid or other health coverage, you must complete the Hawaii Application for Health Coverage & Help Paying Costs. While you wait to learn if you qualify for regular Medicaid or other health coverage, you can get your health services through presumptive eligibility for Medicaid.

You can also apply for regular Medicaid and other health coverage online at mybenefit hawaii.gov, via telephone, in person, or by mail.

Who can	<ul> <li>You can qualify for presumptive eligibility for Medicaid if you meet</li></ul>
qualify for	all of these rules: <ul> <li>Your income is below the monthly limit.</li> <li>You are a U.S. citizen, U.S. national, or eligible non-citizen.</li> <li>You do not already have Medicaid.</li> <li>You have not had presumptive eligibility for Medicaid in the</li></ul>
presumptive	past 12 months. <li>If you are pregnant, you have not had presumptive</li>
eligibility for	eligibility for Medicaid during this pregnancy. <li>You are in one of the groups that qualifies for presumptive</li>
Medicaid?	eligibility for Medicaid: <ul> <li>Children under 19 years of age</li> <li>Parents and caretaker relatives</li> <li>Pregnant women</li> <li>Other adults age 19 – 64 years</li> <li>People under age 26 who were in foster care</li> </ul>
How can I get help with this application?	Ask your hospital representative or call us toll free at 1-800-316- 8005. If you need help in a language other than English, call toll free at 1-800-316-8005 and tell the customer services representative the language you need. We will get you help at no cost to you. TTY/TTD users call toll free at 1-800-603-1201.

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				f
This is an important letter from the Department of Human Services. Please call the phone number located on the letter.	English			
When you call, you will be asked what language you speak and your call will be put on hold for an interpreter. You can also call 1-800-316-8005 for all DHS services.				
這是一封從人類服務部門發出的重要信件。請撥打信上的電話號碼。當你打電話時,你將會被詢問你課什麼語言,您的通話	Cantonese *			
將被攔置直到接通翻譯服務。 其他人類服務部門的服務,您可以致電到 1-800-316-8005.				
El taropwe mi auchchea seni ewe putain tumwunun aramas (Department of Human Services). Kose mwochen kokkori na nampan foon won na taropwe. Nupwen omw kokko, repwe eisinuk menni kkapas ke sine pwe repwe kkutta ngonuk emon choon chiaku. Ka pwan tongeni kokkor 1-300-316-8005 ren meinisin aninnis seni DHS.	Chuukese			
Ceci est une lettre importante du Department of Hurman Services (DHS). S'Il vous plait, faire un appel Héiphonique au numéro de téléphone situé sur la lettre. Lorsque vous téléphonez, quelqu'un va vous demander quelle langue vous parlez, et votre appel sera mis en attente pour un interprête. Vous pouvez aussi téléphoner 1-800-316-8005 pour tous les services de DHS.	French			
Dies ist eon wichtiger Brief von der Abtelung Menschlicher Dienste (DHS). Bitte rufen Sie die Telefonnummer, die auf dem Brief gefunden wurde. Wenn Sie rufen, werden Sie gefragt werden, welche Sprache Sie sprechen, und hr Anruf wird auf Wartestellung für einen Dolmstecher geschaftet werden. Sie können 1–800–316-8005 für ale DHS Denste auch nufen.	German			
He leka ko'iko'i keia mai ka 'Oihana Lawelawe Kanaka (Deparlment of Human Services). E kelepona mai i ka helu kelepona ma luna o ka leka. Ke kelepona 'oe, e ninau 'ia ana 'oe he aha kau 'olelo 'oiwi a laila e kali 'oe a loa'a ke kanaka mahele 'olelo. Hiki pu ia 'oe ke kelepona i 1-800-316-8005 no na lawelawe a pau a ka 'Oihana Lawelawe Kanaka (DHS).	Hawaiian			
Daytoy ket importante nga surat nga naggapu iti Department of Human Services. Pangaasi nga tawagan yo iti numero iti telepono nga nakakabil iti daytoy nga surat. Nu umawag kayo, saludsuden da nu anya iti panagsasao yo ket urayen yo nga maiyallatiw iti tawag yo iti intepreter. Mabalin kayo nga umawayg iti 1-800-316-8005 para kadagiti amin nga serbisyo itii DHS.	llocano			
ハワイ州人道的奉仕局からの大切なお知らせです。 この紙面に書かれている番号にお電話ください。電話をされた時 に、貴方がどの言語を話されているかを聞かれます、 違訳に接続 されるまでしばらくお待ちください。DHSのどの サービスにも、 この電話番号 1-800-316-8005 で対応いたします.	Japanese			
인간 서비스 부서에서 보내는 중요한 편지 입니다. 이편지에 기재된 전화번호로 전화를 하시요. 당신이 전화를 할때 당신이 사용하는 언어를 물을것이고 그언어의 통역인에게 연결할것 입니다. 당신은 모든 인간 서비스 부서(디에이치에스)에 도움을 받기 위해서1-800-316-8005 로 전화 할수 있읍니다	Korean			
这是一封从人类服务部门发出的重要信件。请拨打信上的电话号码。当你打电话时,你将会被询问你讲什么语言, 您的通话将被搁重直到接通翻译服务。其他人类服务部门的服务,您可以致电到 1-800-316-8005。	Mandarin *			
Juon in kojela im elap an aurok im ej itok jen ra eo an department of human services. Jouij im call e nomba in im ej bed ilo pepa in ak letta in. Ne koj call, renej kajitok ibbem kin kain kajin eo am im elikin am ba renej ba kwon kottar bwe ren lewoj juon am ri okok. Komaron call 1-800-316-8005 non aolepen ra ko kajojo ilo DHS services.	Marshallese			
O se fa'asilasilaga ta'ua lenei mai le Ofisa o le Human Services. Fa'amolemole, vala'au mai i le numera lea o lo'o i luga o lenei tusi. À e vala'au mai, o le a fesili atu po'o le a le gagana e te mo'omia, ona tu'u sa'o lea o lau telefoni i se tagata e mafai ona fesoasoani ia oe. E mafai fo'i ona e vala'au i le number 1-800-316-8005 mo nisi 'au'aunaga mai lenei Ofisa."	Samoan			
Ésta es una carta importante de la Sección de Servicios Humanos (DHS). Por tavor llame el número de teléfono localizado en la carta. Cuando usted llama, usted se preguntará qué idioma usted habla y su llamada se pondrá en espera para un intérprete. Usted también puede llamar 1-800-316-8005 para todos los servicios de DHS.	Spanish			
lto ay mahalaga na sulat na galling sa Department of Human Services. Mangyaring tawagan ang numero na nakalagay sa sulat na ito. Kung kayo ay <mark>tatawag,</mark> tatanungin kung ano ang iyong wika at hintayin ninyo hanggat may sumagot na tagasalin. Pwede ninyong tumawag sa 1-800-316-8005 para sa lahat ng serbisio sa	Tagalog			
Ko e tohi mahu'inga eni mei he Potungaue Ngaue Ma'ae Kakai. Kataki 'o telefoni ki he fika 'oku ha 'i he tohi ni. 'E fehu'i atu pe ko e ha e fa'ahinga lea 'oku ke lea'aki 'i he taimi te ke ta mai ai pea tnitokoe ke tali kae 'oua kuo ma'u ha toko taha fakatonu lea. Te ke lava 'o ta ki he ki he ngaahi tokoni kotoa 'a e DHS.	Tongan			
Đảy là lá thơ quang trọng từ các Bộ Phục Vụ Nhân Dân (DHS). Làm ơn gọi xổ điện thoại nằm trên lá thơ. Khi bạn gọi, bạn sẽ được hởi ngôn ngữ nào bạn nói và cú điện thoại của bạn sẽ chở người thông dịch. Đồng thời bạn cùng có thể gọi số 1- 800-316-8005 cho các phục vụ DHS.	Vietnamese Việt Nam			
Kini importante nga sulat gikan sa Department of Human Services (DHS). Palihug tawagi ang numero sa maong telepono nga nahimutang sa sulat. Sa imong pagtawag, ikaw pangutan-on kun unsa ang imong pinulongan ug ang imong tawag ilang ipahulat para sa usa ka taghubad sa pinulongan. Mahimo usab nga imong tawagan ang 1-800- 316-8005 para sa tanang mag serbisyo sa DHS.	Visayan			

TN NO: 13-007-MM7

DHS 1XXXX

Approval Date November 18, 2015

DHS 10000

TEP-11 Tell·us·about·yours
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Weineedioneiadultii	n·the·family·to·be·the·con	tact∙person·fo	r·your·application.··=		-
1First-Name=	Middle-name=		⊷Last∙name≖	Suffix=	
2. Home address (Leav	e·blank·lf·you·don't·have·o	ne.)¤		-3Apartment-or-suite	•number= _
4Clty≖		·5State=	·6ZIP·code≃	·7County=	
8Mailing-address-(if-dif	fferent-from-home-address	•		·9Apartment-or-suite	•number= =
10City=		·11.·State=	·12.·ZIP·code=	·13County≖	
14.·Phone·number¶ ( → )¤			·15Other-phone-nu ·( → )¤	ımber¶	
16Do-you-want-to-get-l Email-address:	information - about - this - appl	cation-by-ema	II?YesNo¶		
17What-Is-your-preferm	ed-spoken-language-(lf-not	-English)?=	18What-Is-your-preferred	d-written-language-(lf-not-English)¤	

#### STEP-2 Tell·us·about·your·family.¶

List yourself and the members of your immediate family who live with you. Include your spouse, your children under the = age of 19 years if they live with you and anyone you include on your tax return, even if they don't live with you.a

Name-¶ (first, middile, last)=	Date-of-birth- (XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	Relationship to-you≖	presumptive eligibility for- Medicald? +	Medicald-or- other-medical-	U.S. National-	Hawall¶ (Yes-or-No)¤	Social-Security-Number- (SSN)-(You-don't-have-to- provide-this-now,-but-it-helps- us determine-eligibility-for- regular-Medicald-faster)¶ ¶
				Answer for fa applying, you person.¤	mily-members •do-not-have-t	who are apploanswer thes	ying. If a person is not- e questions for that-
(Same-as-above)≃	8	(Self)¤	a.	a	a	R	×
8	8	×	×	×	×	×	8
×	×	×	×	α	¤	¤	×
a.	2	×	×	×	×	×	¤
		Section	Break (N	lext Page	)		

STEP 3	Other o
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#### uestions.

Answer these questions for yourself and your family members listed in Step 2. You out if you and any family member(s) qualify.	r answers will make it easier to find
s anyone pregnant who is applying for presumptive eligibility for Medicaid?	🗆 Yes 🗆 No
fyes, who? How	nany babies does she expect?
s anyone who is applying for presumptive eligibility for Medicaid receiving Medicare or Social Security In	oome (SSI)? □ Yes □ No
fyes, who?	
s anyone who is applying for presumptive eligibility for Medicaid a parent or caretaker relative? For example, a grandparent who is the main person taking care of a child.	□Yes □No
fyes, who?	
Was anyone who is applying for presumptive eligibility for Medicaid in foster care at age 18?	🗆 Yes 🗆 No
f yes, who?	

#### STEP 4 Tell us about your family's income.

Write the total income before taxes are taken for	Write the total income before taxes are taken for all family members listed in Step 2.				
Job income: For example, wages, salaries, an	d self-employment incom	e.			
Amount \$	How often? (check one)	U Weekly	Biweekly	Monthly	□ Yearly
Other income For example, unemployment cl ("SSDI"). Do not include Supplemental Security					iinistration
Amount \$	How often? (check one)	U Weekly	Biweekly	Monthly	□ Yearly

TN NO: 13-007-MM7

Approval Date November 18, 2015

DHS 1XXXX

Effective Date: January 1, 2014

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### STEP-5 Read ·& ·sign ·this ·application.

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- •- I'm-signing-this-application-under-penalty-of-perjury-which-means-il-ve-provided-true-answers-to-all-questions-this form-to-the-best-of-my-knowledge...-i-know-that-I-may-be-subject-to-penalties-under-state-or-federal-law-if-I-providefalse-or-untrue-information...¶
- I-understand-that-under-federal-law,-discrimination-isn't-permitted-on-the-basis-of-race,-color,-national-origin,-sex,age,-secual-orientation,-gender-identity,-or-disability.-I-can-file-a-compliant-of-discribmiation-by-visitingwww.hhs.gov/ocr/office/file.--¶
- ●→ The person who filled out Step 1-should sign this application. ¶

•					
Signature¶	Date-(mm/dd/yyyy)-¶ "				
	1				
а					
¶Section Break (C	Continuous)				
STEP-6¶ If you qualify for presur happens next?¶	nptive-eligibility·for-Medicaid,·what·				
•- You-will get a notice from the hospital saying you were	approved.¶ "				
	prescription-drugs. You-can-go-to-any-health-care-provider- edTo-start-using-your-presumptive-eligibility-for-Medicaid,-				
	ealth-coverage, the hospital will help you fill out the Hawaii if you choose, - You can also apply for regular Medicaid and ria telephone, in person, or by mail¶				
<ul> <li>Your-presumptive-eligibility-will-end-on-the-date-you If-you-are-denied,-you-will-be-referred-to-the-Connector-</li> </ul>	ur application for Medicaid is either approved or denied. for other affordable insurance programs.¶				
<ul> <li>If you do not fill out and submit the Hawaii Applicat you qualify for regular. Medicaid or other health coverag on the last day of the month after the month you are ap</li> </ul>	ge, your presumptive eligibility for Medicaid coverage will end				
For example, if you qualified for presumptive eligibility f of February=	for Medicaid in January, it will end on the last day ↔				
Section Break (C	ontinuous)				
	·presumptive·eligibility·for·Medicaid,·				
You will get a notice from the hospital saying you were not	approvedYou-cannot-appeal-the-hospital's-decisionBut-				

You will get a notice from the hospital saying you were not approved. "You cannot appeal the hospital's decision. "But you can still apply for regular Medicaid or other health coverage using the Hawaii Application for Health Coverage & Help Paying Costs. • a

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## **Sample Approval Letter**

State of Hawaii – Dept. of Human Services Med-QUEST Division Street address Honolulu, HI 96813



#### Applicant name: Jane Doe,

Thank you for your Hospital Presumptive Eligibility (HPE) application dated January 2, 2015. We have reviewed the information you provided on the application and have made the following eligibility determination:

Name	
DOB	MM/DD/mm
ID	XXXXXXXXX
Application Status	Approved
Coverage group	HPE: Pregnant Women group
Effective Date	January 2, 2015
Termination Date	Date of approved or denied eligibility for regular Medicaid or February 28, 2015 if no DH5 1100 is completed and submitted
Household size	2
Countable income	\$1,800
Applicable Income Standard	\$2,157

Additional Information:

Use this letter to as proof of eligibility for the approved household member listed above. If you completed the DHS 1100 "Application for Health Coverage & Help Paying Costs" with help from the hospital staff, it will be sent to the Med-QUEST office to determine your eligibility for regular Medicaid, even if your application for HPE assistance was denied.

Your HPE will end on the date your application for regular Medicaid is either approved or denied by the Med-QUEST office. If you are approved, you will receive regular Medicaid. If you are denied, you will be referred to the Connector for other affordable insurance programs. Med-QUEST will send you a notice of the eligibility determination for regular Medicaid separately.

If you did not complete the application for regular Medicaid, your HPE will end on the last day of the month after the month your HPE application was approved.

If you have questions or need more information contact 1-800-316-8005.

Authority: H.A.R. 17-1711.1-30, 17-1714.1-2

If you are a TTY user or need help in a language other than English, call the phone number located on the letter. We will get you help at no cost.

Page 1 of 1

## **Sample Denial Letter**



## **Attestation Sheet for DHS 1100**

	Name of Hospital
for the Hospi by signing th	of this form is to ensure the above hospital is meeting Department requirements ital Presumptive Eligibility (HPE) program. Signing this form is optional. However, is form, you help the Department to verify the hospital is in compliance with uirements to continue participation in the HPE program.
certify that	: Name of hospital staff member
h Costs form;	elped me complete the DHS 1100 Application for Health Coverage & Help Paying
Dr	
	explained the purpose of the DHS 1100 Application for Health Coverage & Help form and offered to help applicant to fill out the form, but applicant chose not to at this time.
rint name o	of HPE applicant

## **Sample of Cover Letter**

	HPE PACKET COVER SHEET
	Name of Hospital
To:	MQD/EB Unit FAX Number:
Fron	
1101	r: FAX Number: Telephone Number:
	:
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	TEW AND PROCESS FOR MEDICAID ELIGIBILITY: HPE Packet Cover Sheet HPE Application with Approval/Denial Notice
	TEW AND PROCESS FOR MEDICAID ELIGIBILITY: HPE Packet Cover Sheet HPE Application with Approval/Denial Notice DHS 1100 "Application for Health Coverage &Help Paying Costs" and/or
	TEW AND PROCESS FOR MEDICAID ELIGIBILITY: HPE Packet Cover Sheet HPE Application with Approval/Denial Notice DHS 1100 "Application for Health Coverage &Help Paying Costs" and/or
	TEW AND PROCESS FOR MEDICAID ELICIBILITY: HPE Packet Cover Sheet HPE Application with Approval/Denial Notice DHS 1100 "Application for Health Coverage &Help Paying Costs" and/or DHS 1100 Attestation Sheet

Effective Date: January 1, 2014

Application for Health Coverage & Help Paying Costs

State of Hawai

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THINGS

Department of Human Services

Hawaii Health Connector

<ul> <li>Who can use this application to apply for you or anyone in your family.</li> <li>Apply even if you or your child already has health coverage. You could be eligible for lower-cost or free coverage.</li> <li>Families that include immigrants can apply. You can apply for your child aven if you aren't eligible for coverage. Applying won't affect your immigration status or chances of becoming a permanent resident or citizen.</li> <li>If someone is helping you fill out this application, you may need to complete Appendix C.</li> <li>Apply faster online         <ul> <li>Apply faster online at <u>mybenefits.hawaii.gov</u>.</li> <li>If you want to purchase insurance without help, apply directly at <u>hawaiihealthconnector.com</u></li> </ul> </li> <li>What you may need to apply</li> <li>Social Security Numbers (or document numbers for any legal immigrants who need insurance)</li> <li>Employer and income information for everyone in your family (for example, from paysiubs, W-2 forms, or wage and tax statements)</li> <li>Policy numbers for any current health insurance available to your family</li> <li>Why do we ask for this information?</li> <li>What happens next?</li> <li>Send your complete, signed application to the address on page 7. If you don't have all the information or sets for, sign and submit your application anyway. We'll follow-up with you waithin 1–2 weeks. You'll get instructions on the next steps to complete for assistance with completing out this application anyway. We'll follow-up with you within 1–2 weeks. You'll get instructions on the next steps to complete for assistance with completing and submit your application anyway. We'll follow-up with you within 1–2 weeks. You'll get instructions on the next steps to complete your health coverage.</li> <li>Online: mybenefits.hawaii.gov or call 4.977-628-5076 for assistance with completing and submitting an application.</li> <li>Online: mybenefits.hawaii.gov area who can help</li></ul>			
<ul> <li>Apply faster online         <ul> <li>If you want to purchase insurance without help, apply directly at hawaiihealthconnector.com</li> </ul> </li> <li>What you may need to apply         <ul> <li>Social Security Numbers (or document numbers for any legal immigrants who need insurance)</li> <li>Employer and income information for everyone in your family (for example, from paystubs, W-2 forms, or wage and tax statements)</li> <li>Policy numbers for any current health insurance</li> <li>Information about any job-related health insurance available to your family</li> </ul> </li> <li>Why do we ask for this information?</li> <li>We ask about income and other information to let you know what coverage you qualify for and if you can get any help paying for it. We'll keep all the information you provide private and secure, as required by law. To view the Privacy Act Statement, go to mybenefits.hawaii.gov.</li> <li>What happens next?</li> <li>Send your complete, signed application to the address on page 7. If you don't have all the information we ask for, sign and submit your application on the next steps to complete your health coverage. If you don't have all the information we ask for, sign and submit your application anyway. We'll follow-up with you within 1-2 weeks. You'll get instructions on the next steps to complete your health coverage.</li> </ul> <li>Get help with this application doesn't mean you have to buy health coverage.</li> <li>Online: mybenefits.hawaii.gov</li> <li>Phone: Call the Contact Center at 1-877-628-5076 for assistance with completing and submitting an application.</li> <li>In person: There may be counselors in your area who can help. Visit our wesite or call 1-877-628-5076 for new information.</li> <li>Medicait: For specific questions on Medicaid/CHIP eligibility, call</li>	3		<ul> <li>Apply even if you or your child already has health coverage. You could be eligible for lower-cost or free coverage.</li> <li>Families that include immigrants can apply. You can apply for your child even if you aren't eligible for coverage. Applying won't affect your immigration status or chances of becoming a permanent resident or citizen.</li> <li>If someone is helping you fill out this application, you may need to</li> </ul>
<ul> <li>What you may need to apply</li> <li>immigrants who need insurance)</li> <li>Employer and income information for everyone in your family (for example, from payslubs, W-2 forms, or wage and tax statements)</li> <li>Policy numbers for any current health insurance</li> <li>Information about any job-related health insurance</li> <li>Information about any job-related health insurance available to your family</li> <li>Why do we ask for this information?</li> <li>We ask about income and other information to let you know what coverage you qualify for and if you can get any help paying for it. We'll keep all the information you provide private and secure, as required by law. To view the Privacy Act Statement, go to mybenefits.hawaii.gov.</li> <li>What happens next?</li> <li>Send your complete, signed application to the address on page 7. If you don't have all the information we ask for, sign and submit your application anyway. We'll follow-up with you within 1-2 weeks. You'll get instructions on the next steps to complete your health coverage.</li> <li>Get help with this application doesn't mean you have to buy health coverage.</li> <li>Online: mybenefits.hawaii.gov</li> <li>Online: Call the Contact Center at 1-877-628-5076 for assistance with completing and submitting an application on the status of your application.</li> <li>In person: There may be counselors in your area who can help. Visit our website or call 1-877-628-5076 for more information.</li> <li>Medicaid: For specific questions on Medicaid/CHIP eligibility, call</li> </ul>		Apply faster online	<ul> <li>If you want to purchase insurance without help, apply directly at</li> </ul>
<ul> <li>Why do we ask for this information?</li> <li>Why do we ask for this information?</li> <li>What happens next?</li> <li>Send your complete, signed application to the address on page 7. If you don't have all the information we ask for, sign and submit your application anyway. We'll follow-up with you within 1-2 weeks. You'll get instructions on the next steps to complete your health coverage. If you don't have all the information we ask for, sign and submit your application anyway. We'll follow-up with you within 1-2 weeks. You'll get instructions on the next steps to complete your health coverage. If you don't have all the information we ask for, sign and submit your application doesn't mean you have to buy health coverage.</li> <li>Get help with this application</li> <li>Online: mybenefits.hawaii.gov</li> <li>Phone: Call the Contact Center at 1-877-628-5076 for assistance with completing and submitting an application.</li> <li>In person: There may be counselors in your area who can help. Visit our website or call 1-877-628-5076 for Help With, call</li> </ul>	D		<ul> <li>immigrants who need insurance)</li> <li>Employer and income information for everyone in your family (for example, from paystubs, W-2 forms, or wage and tax statements)</li> <li>Policy numbers for any current health insurance</li> <li>Information about any job-related health insurance available to your</li> </ul>
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coverage to help you stay well

Insurance Program (CHIP)

health coverage

Affordable private health insurance plans that offer comprehensive

A new tax credit that can immediately help pay your premiums for

Free or low-cost insurance from Medicaid or the Children's Health

This is an important letter from the Department of Human Services. Please call the phone number located on the letter English When you call, you will be asked what language you speak and your call will be put on hold for an interpreter. You can also call 1-888 - 764-7586 for all DHS services

Cantonese 這是一封從人類服務部門發出的重要信件。請撥打信上的電話號碼。當你打電話時……你將會被範圍你讓什麼語言……您的通話 將被擱置直到接通翻譯服務。其他人類服務部門的服務,您可以致電到 1-888-764-7586 Ei taropwe mi auchchea seni ewe putain tumwunun aramas (Department of Human Services). Kose mwochen kokkori Chuukese na nampan foon won na taropwe. Nupwen omw kokko, repwe eisinuk menni kkapas ke sine pwe repwe kkutta ngonuk emon choon chiaku. Ka pwan tongeni kokkori 1-888-764-7586 ren meinisin aninnis seni DHS. Ceci est une lettre importante du Department of Human Services (DHS). S'il yous plaît, faire un appel téléphonique au numéro. French de téléphone situé sur la lettre. Lorsque vous téléphonez, quelqu'un va vous demander quelle langue vous parlez, et votre appel sera mis en attente pour un interprète. Vous pouvez aussi téléphoner 1-888 - 764-7586 pour tous les services de DHS. Dies ist eon wichtiger Brief von der Abteilung Menschlicher Dienste (DHS). Bitte rufen Sie die Telefonnummer, die auf dem Brief German gefunden wurde. Wenn Sie rufen, werden Sie gefragt werden, welche Sprache Sie sprechen, und Ihr Anruf wird auf Wartestellung. für einen Dolmetscher geschaltet werden. Sie können 1-888-764-7586 für alle DHS Dienste auch rufen. He leka koʻikoʻi keja maj ka 'Ojhana Lawelawe Kanaka (Department of Human Services). E kelepona maj i ka helu Hawaiian kelepona ma luna o ka leka. Ke kelepona 'oe, e ninau 'ia ana 'oe he aha kau 'olelo 'oiwi a laila e kali 'oe a loa'a ke XK___ kanaka mabele olelo. Hiki pu ia 'oe ke kelepona i 1-888-764-7586 no na lawelawe a pau a ka 'Qibana Lawelawe Kanaka (DHS) Dayloy ket importante nga surat nga naggapu iti Department of Human Services. Pangaasi nga tawagan vo iti numero iti telegono. llocano nga nakakabil iti daytoy nga surat. Nu umawag kayo, saludsuden da nu anya iti panagsasag yo ket urayen yo nga maiyallatiw iti. tawag yo iti intepreter. Mabalin kayo nga umawayo iti 1-888-764-7586 para kadagiti amin nga serbisyo iti DHS. ハワイ州人道的幸仕局からの大切なお知らせです。 この紙面に書かれている番号にお電話ください。 電話を された時 Japanese に、曾方がどの言語を話されているかを聞かれます、 遥訳に接続 されるまでしばらくお待ち ください。DHSのどの サービスにも、この電話番号1-888-764-7586で対応いたします 인간 서비스 부서에서 보내는 중요한 편지 입니다. 이편지에 기재된 전화번호로 전화를 하시요. 당신이 전화를 할때 당신이 Korean 사용하는 언어를 물을것이고 그언어의 통역인에게 연결할것 입니다. 당신은 모든 인간 서비스 부서(디에이치에스)에 도움을 **(**•); 받기 위해서 1-888-764-7586 로 전화 할수 있읍니다 这是一封从人类服务部门发出的重要信件。请拨打信上的电话号码。当你打电话时,你将会被询问你进什么语言。 <u>Manda</u>rin 您的通话将被搁置直到接通翻译服务。其他人类服务部门的服务,您可以致电到 1-888 -764-7586。 Marshallese Juon in kojela im elap an aurok im ei itok jen ra eo an department of human services. Jouji im call e nomba in im ei bed ilo pepa in ak letta in. Ne koj call, renej kajitok ibbem kin kajn kajn eo am im elikin am ba renej ba kwon kottar bwe ren ~ lewoj juon am ri okok. Komaron call 1-888-764-7586 non aolepen ra ko kajojo jio DHS services. O se fa'asilasilaga ta'ua lenei mai le Ofisa o le Human Services. Fa'amolemole, vala'au mai i le numera lea o lo'o i luga Samoan o lenei tusi. A e vala au mai, o le a fesili atu pojo le a le pagana e te mojomia, ona tuju sajo lea o lau telefoni i se tagata. 12 E e mafai ona fesoasoani ja oe. E mafai fo'i ona e vala'au i le number 1-888-764-7586 mo nisi 'au'aunaga mai lenei Ofisa." <u>Ésta es una carta importante</u> de la <u>Sección de Servicios Humanos (DHS). Por</u> favor llame el número de teléfono Spanish localizado en la carta. Cuando usted llama, usted se prepuntará qué idioma usted habla y su llamada se pondrá (楽) en espera para un intérprete. Usted también puede llamar, 1-888 - 764-7586 para todos los servicios de DHS. Tagalog Ito ay mahalaga na sulat na galling sa Department of Human Services. <u>Mangyaring tawagan ang numero na nakalagay</u> sa sulat na ito. Kung kayo ay tatawag, tatanungin kung ang ang iyong wika at hintayin ninyo hanggat may sumagot na tagasalin. Pwede ninyong tumawag sa 1-888-764-7586 para sa lahat ng serbisio sa DHS. Ko e tobi mahu'inga eni mei he Potungaye. Ngaye Ma'ae Kakai. Kataki 'o telefoni ki he fika 'oku ha 'i he tobi ni. 'E febu'i. Tongan atu pe ko e ha e fa'ahinga lea 'oku ke lea'aki 'i he taimi te ke ta mai ai pea thitokoe ke tali kae 'oua kuo ma'u ha toko taha + fakatonu lea. Te ke lava 'o ta ki he ki he ngaahi tokoni kotoa 'a e DHS. Đây là lá thơ quang trong từ các Bộ Phục Vụ Nhân Dân (DHS). Làm ơn gọi xố điện thoại nằm trên lá thơ. Khi ban gọi, ban Vietnamese sẻ được hỏi ngôn ngữ nào ban nói và cú điện thoại của ban sẻ chờ người thông dịch. Đồng thời ban cùng có thể gọi số 1-Việt Nam 888-764-7586 cho các phục vụ DHS. Kini importante nga sulat gikan sa Department of Human Services (DHS). Palihug tawagi ang numero sa maong Visayan telepong nga nahimutang sa sulat. Sa imong pagtawag, ikaw pangutan-on kun unsa ang imong pinulongan ug ang. imong tawag ilang ipahulat para sa usa ka taghubad sa pinulongan. Mahimo usab nga imong tawagan ang 1-888-764-

November 180 2015 HYOUR APPLICATION? Visit myber Effective Dates / January 12 2014 ..... , call 1-877-628-5076 and tell the customer service

NEN: NOTH 193-007-MM7tt mybenefits. hawaii.gov or call us at 1-877-628-507 Approval Date other than English, call 1-877-628-5076 and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY/TDD users should call 1-855-858-8604.

DHS 1100 (REV. 10/14)

7586 para sa tanang mga serbisyo sa DHS.

cost to you. TTY/TDD users should call 1-855-858-8604.

### STEP

(We need one adult in the family to be the contact person for your application.)

Tell us about vourself.

1. First name	Middle name		Last name		Suffix
<ol> <li>Home address (Leave blank if you don't have on</li> </ol>	e.)			3. Apartment or suite nu	mber
4. City	5. State	8. Zip cod	e	7. County	
8. Mailing address (if different from home address)				9. Apartment or suite nu	mber
10. City	11. State	12. Zip co	de	13. County	
14. Phone number		15. Other	phone number		
( ) -		C	) –		
16. Do you want to get information about this applic	ation by email? 🔲 Ye	s 🔲 No			
Email address:		_			
17. What is your preferred spoken language (if not B	English)?	18. What is yo	our preferred writte	n language (if not English)?	
19. How many family members live with you?		jailed) or n	esiding in the Haw	sually live with incarcerated (d raii State Hospital? me(s):	etained or

#### STEP 2 Tell us about your family.

#### Who do you need to include on this application?

Tell us about all the family members who live with you. If you file taxes, we need to know about everyone on your tax return. (You don't' need to file taxes to get health coverage).

#### DO Include:

- · Yourself
- Your spouse
- · Your children under 19 who live with you
- · Your unmarried partner who needs health coverage
- · Anyone you include on our tax return, even if they don't live with you
- Anyone else under 19 who you take care of and lives with you

The amount of assistance or type of program you qualify for depends on the number of people in your family and their incomes. This information helps us make sure everyone get the best coverage they can.

Complete Step 2 for each person in your family. Start with yourself, then add other adults and children. If you have more than two (2) people in your family, you'll need to make a copy of the pages and attach them. You don't need to provide immigration status or a Social Security Number (SSN) for family members who don't need health coverage. We'll keep all the information you provide private and secure as required by law. We'll use personal information only to check if you're eligible for health coverage.

#### TN NO: 13-007-MM7 2

#### NEED HELP WITH YOUR APPLICATION? Visit mybenefits.hawaii.gov or call us at 1-877-628-5076. If you need help in a language other than English, call 1-877-628-5076 and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY/TDD users should call 1-855-858-8604.

#### DHS 1100 (REV. 10/14)

- You DON'T have to include:
- · Your unmarried partner who doesn't need health coverage
- Your unmarried partner's children Your parents who live with you, but file their own tax return
- (if you're over 19) · Other adult relatives who file their own tax return

#### STEP 2: PERSON 1 (Start with yourself)

First r	name		Middle name			Last name			Suffix	2. Relation SELF	nship to y	ou?
Date	of birth (mm/dd/y					4. Gen	ler 🔲 M	lale 🔲	Female			
	I Security Numbe											
	eed this if you w peed up the appli											
	If someone war											age
-												
	ou plan to file a can still apply fo					ncome tax ret	ım.)					
_				_				_				
	Yes. If yes, ple	ase answer (	juestions a-c.		NQ. IT	no, skip to	question (	C.				
a. 1	Will you file jointly	y with a spous	e? 🔲 Y	es 🗌	No							
1	lfyes, name of	spouse:										
b. \	Will you claim an	y dependents	on your tax retu	ım? 🔲	Yes	No No						
	If yes, list name(	s) of depender	nts:									
c. 1	Will you be claim	ed as a depen	dent on someo	ne's tax retu	rn?	🔲 Yes	🔲 N	lo				
	l <b>f yes</b> , please list	the name of t	he tax filer:									
	How are you rela	ted to the text	Eler?									
,	How are you rela	ted to the tax	merr									
Are	you pregnant?	🗌 Yes 🔲	No If yes, ho	w many bab	bies are	expected duri	ng this pre	gnancy?		Expected D	Due Date	
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Approval Date November 18, 2015 NEED HELP WITH YOUR APPLICATION? Visit mybenefits hawaii.gov or call us at 1-877-528-5076. If you need help in a language other than English, call 1-877-628-5076 and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY/TDD users should call 1-855-858-8604. DHS 1100 (REV. 10/14)

Page 2 of 7

Page 3 of 7

	RSON 1 (Continue		
Employed If you're currently en about your income question 18.	nployed, tell us Sk	elf-employed kip to question 27.	Not employed Skip to question 28.
CURRENT JOB 1:			
18. Employer name and a	Idress		19. Employer phone number
20. Wages/tips (before tax	es) 🔲 Hourly 🔲 Weekly	Exerx 2 weeks 🔲 Twice	a month 🔲 Monthly
21. Average hours worked	each WEEK		
CURRENT JOB 2: (	If you have more jobs and need more s	space, attach another sheet of pa	per.)
22. Employer name and a	· · ·		23. Employer phone number
24. Wages/tips (before tax	es) 🔲 Hourly 🔲 Weekly	Exerx 2 weeks 🔲 Twice	a month 🔲 Monthly
25. Average hours worked	each WEEK		
28. Jo the past year, did y	you: 🔲 Change jobs 🔲 Sto	op working 🔲 Start working fe	wer hours 🔲 None of these
27. If self-employed, answ	er the following questions:		
a Type of work			ncome (profit business expenses are paid) will you get
		from this self-em	ployment this month?
	THIS MONTH: Check all that app tell us about child support or veteran's		often you get it.
Unemployment	\$ How often?	Net farming/fishing \$	How often?
Pensions	\$ How often?		
Social Security	\$ How often?		How often?
Retirement accounts		Type:	
Alimony received	\$ How often?		
	heck all that apply, and give the amou s that can be deducted on a federal inc		hem could make the cost of health coverage a little
	ude a cost that you already considered	in your answer to net self-emplo	vment (question 27b).
Alimony paid	\$ How often?		\$ How often?
Student loan interest		Type:	
	• How once::	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
	COME: Complete if your net income nanges to your monthly income, skip		th.
Your total income this yea			income next year (if you think it will be different)
\$		\$	
\$		all we need to know a	about you. RSON 2 (Pages 4 and 5) and Complete
s If there is 2 or TNNC	more people to include, please in <b>13-007-MM7</b>	all we need to know a make a copy of STEP 2: PEF	RSON 2 (Pages 4 and 5) and Complete Approval Date
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STEP 2: PERSON 2
complete Step 2 for yourself, your spouse/partner and children who live with you and/or anyone on your same federal income tax return if you file
ne. See page 1 for more information about who to include. If you don't file a tay return, remember to still add family members who live with you

c. Does PERSON 2 need long term care nursing services now? Yes No   11. Did PERSON 2 receive Supplemental Security Income (SSI)? Yes No   11. Did PERSON 2 receive say medical services in the past ten (10) celendar days immediately prior to the date of this application? No   12. Is PERSON 2 a U.S. citizen or U.S. national? Yes. If yes, skip to Question 14. No   13. If PERSON 2 a U.S. citizen or U.S. national? Yes. If yes, skip to Question 14. No   14. Is PERSON 2 a U.S. citizen or U.S. national. please provide the information below. a. Immigration document type   b. Document ID number   c. When did PERSON 2 enter the U.S.? .   d. Is PERSON 2 a clitzen or the rederated State of Micronesia, the Republic of the Marshall Islands or Palau? Yes   No .   14. Is PERSON 2 the primary or one of the primary person(s) taking care of a child under age 19 years that lives with you? Yes   15. Was PERSON 2 in foster care at age 18 or older in Hawaii? Yes No   16. Is PERSON 2 a full-time student? Yes No   17. If Hippanic/Latino, ethnicity (OPTIONAL—check all that apply.) Mexican, American American Filipino   White Black or African American Filipino Vietnamese   B. Race (OPTIONAL—check all that apply.) White Black or African American   Mexican Mexican Indian or Alaska Native Japanese Other Asian   Asian Indian American Indian or Alaska Native Japanese Other Asian   Chinese Native Hawaian K	1. First name	Middle name	Last nam	e		Suffix	2. Relationsh	ip to PERSC	)N 1
5. Social Security Number (SN) We need this if you want health coverage and have an SSN. 6. Does PERSON 2 live at the same address as you? If we is if you want health income tax return NEXTYEAR? (You can still apply for health insurance even if you don't file a federal income tax return.) If ves. If yes, please answer questions a-c. No. If no, SKI down Will PERSON 2 the jointly with a spouse? Yes No If yes, name of spouse: If yes, isin name(s) of dependents: If yes, isin name(s) of dependents: If yes, list name(s) of dependents: If yes, please last the name of the tax filer? How is PERSON 2 be daimed as a dependent on someone's tax return? If yes, please last the name of the tax filer? How is PERSON 2 need health coverage? If yes, if yes, naswer all the questions below. If a PERSON 2 have a disability that will last more than twelve (12) months? If yes, in yes, inswer all the questions below. If yes, in yes, naswer all the questions below. If yes, in yes, naw details and the paster (10) calendar days immediately pror to the date (5)? If yes. If yes, nawer all the questions below. If yes, in yes, naw disability that will last more than twelve (12) months? Yes, in yes, what date(s)? If yes. If yes, nawer all the questions below. If yes. If yes, nawer all the questions are nursing services inty? Yes is not head of the safet (12) months? Yes. If yes, in my home in the community Is that pERSON 2 need vealing services inty each not sign services inty? Yes, in yes, what date(s)? Use SPERSON 2 need vealing services inty each not sign services inty? Yes is types, what date(s)? Is Dese PERSON 2 need vealing services inty each not sign mathemately pror to th	3. Date of birth (mm/dd/yyyy)			4. Gender	r 🔲 Male	Fema	le		
We need this if you want health coverage and have an SSN.         0. Does PERSON 2 live at the same address as you?       Yes       No         17. Does SERSON 2 plue to the a federal income tax return NEXTYEAR?       (You can still apply for health insurance even if you don't file a federal income tax return.)         17. Yes. If yes, please answer questions a-c.       No, If no, Ist address:       No         17. WIPERSON 2 file jointly with a spouse?       Yes       No         18. WIPERSON 2 file jointly with a spouse?       Yes       No         19. WIPERSON 2 file jointly with a spouse?       Yes       No         19. WIPERSON 2 file jointly with a spouse?       Yes       No         19. WIPERSON 2 be claimed as a dependent on someone's tax return?       Yes       No         19. WIPERSON 2 pregnant?       Yes       No         19. WIPERSON 2 pregnant?       Yes       No         19. Deas PERSON 2 redelated to the tax filer?									
If no. list address:			 SN.						
(You can still apply for health insurance even if you don't file a federal income tax return.) <ul> <li>Yes. If yes, please answer questions a=o.</li> <li>No. If no, skip to question c.</li> </ul> Will PERSON 2 file jointly with a spouse? <ul> <li>Yes</li> <li>No.</li> <li>If yes, name of spouse:</li> <li>Will PERSON 2 be claimed as a dependent on someone's tax return?</li> <li>Yes</li> <li>No</li> <li>If yes, list name(s) of dependents:</li> <li>Will PERSON 2 be claimed as a dependent on someone's tax return?</li> <li>Yes</li> <li>No</li> <li>If yes, please list the name of the tax filer?</li> <li>How is PERSON 2 need health coverage?</li> <li>(Even if they have insurance, three might be a program with better coverage or lower costs.)</li> <li>Yes. If yes, answer all the questions below.</li> <li>No. If no, SKIP to the income questions on page 5. Leave the rest of this page blank.</li> </ul> <li>Does PERSON 2 need health coverage?</li> <li>(Even if they have insurance, three might be a program with better coverage or lower costs.)</li> <li>Yes. If yes, answer all the questions below.</li> <li>No. If no, SKIP to the income questions on page 5. Leave the rest of this page blank.</li> <li>Does PERSON 2 needved long term care nursing services:         <ul> <li>Yes. If yes, what date(s)?</li> <li>Des PERSON 2 needved long term care nursing services:             <ul> <li>Yes. If yes, what date(s)?</li> <li>Des PERSON 2 needved Supplemental Security Income (S3)?</li> <li>Yes in No</li> <li>Des PERSON 2 acetaits or the past ten</li></ul></li></ul></li>		me address as you?	Yes 🗌	No					
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If yes, name of spouse:         b. Will PERSON 2 claim any dependents on his/her tax return?       Yes       No         If yes, list name(s) of dependents:	🔲 Yes. If yes, please an	swer questions a-c.	🔲 No. If no, s	kip to qu	estion c.				
b. Will PERSON 2 claim any dependents on his/her tax return? Yes No   H yes, list name(s) of dependents: .   c. Will PERSON 2 be claimed as a dependent on someone's tax return? Yes No   H yes, please list the name of the tax filer:	a. Will PERSON 2 file joint	with a spouse?	Yes 🗌	No					
If yes, list name(s) of dependents:         0. Will PERSON 2 be claimed as a dependent on someone's tax return?       Yes       No         If yes, please list the name of the tax filer:	If yes, name of spouse								
c. Will PERSON 2 be claimed as a dependent on someone's tax retur? Yes No   If yes, please list the name of the tax filer:			turn?	Yes	🔲 No				
If yes, please list the name of the tax filer:         How is PERSON 2 related to the tax filer?         8. Is PERSON 2 pregnant?       Yes       No       If yes, how many bables are expected during this pregnancy?       Expected Due Date         9. Does PERSON 2 need health coverage?       [Even if they have insurance, there might be a program with better coverage or lower costs.)       No       No         9. Yes. If yes, answer all the questions below.       Image: State the rest of this page blank.         10. Does PERSON 2 have a disability that will last more than twelve (12) months?       Yes. In anusing facility       Yes, in my home in the community         10. Does PERSON 2 need long term care nursing services in the last three (3) months?       Yes. If yes, what date(s)?          c. Does PERSON 2 receive Supplemental Security Income (SSI)?       Yes       No         11. Did PERSON 2 receive any medical services in the past ten (10) calendar days immediately prior to the date of this application?       Yes. If yes, what date(s)?         c. Is PERSON 2 receive any medical services in the past the information below.       No         12. Is PERSON 2 active or U.S. national?       Yes. If yes, skip to Question 14.       No         13. If PERSON 2 a clitzen or U.S. national, please provide the information below.        Immigration document type       No         b. Document ID number       0. Steperson 2 enther bulls.?       Yes       No									_
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Ves. If yes, answer all the questions below. No. If no, SKIP to the income questions on page 5. Leave the rest of this page blank. 10. Does PERSON 2 currently receive long term care nursing services in the last three (3) months? Yes, in yes, what date(s)? 0. Does PERSON 2 receives Usplemental Security Income (SII)? Yes No 11. Did PERSON 2 receives Usplemental Security Income (SII)? Yes No 12. Is PERSON 2 active of U.S. national? Yes. If yes, skip to Question 14. No 12. Is PERSON 2 active of U.S. national? Yes. If yes, skip to Question 14. No 13. Did PERSON 2 active of U.S. national? Yes. If yes, skip to Question 14. No 14. Is PERSON 2 a U.S. ditizen or U.S. national, please provide the information below. a. Impravious of the Person 2 recent a vetram or an active-duty member of the U.S. military? Yes No 14. Is PERSON 2 a cutter of the primary person(s) taking care of a child under age 19 years that lives with you? Yes No 15. Was PERSON 2 the primary or one of the primary person(s) taking care of a child under age 19 years that lives with you? Yes No 16. Is PERSON 2 a full-time student? Yes No 17. If Hipspnic/Latino, ethnicity (OPTIONAL—check all that apply.) Mexican, American Indian or Alaska Native Japanese Other Asian Indian Asian Indian American Areican Answire Asian Indian Asian Indian American Areican Answire Mow, tell us about any income from PERSON 2 on the back Korean No, tell us about any income from PERSON 2 on the back			h better coverage	or lower co	osts.)				_
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a. Does PERSON 2 currently receive long term care nursing services:  Yes, in an unsing facility Yes, in my home in the community b. Has PERSON 2 receive a comparison and the last three (3) months? Yes No Does PERSON 2 receive supplemental Security income (SSI)? Yes No Does PERSON 2 receive supplemental Security income (SSI)? Yes No Does PERSON 2 receive supplemental Security income (SSI)? Yes No Does PERSON 2 receive supplemental Security income (SSI)? No Ls PERSON 2 receive supplemental Security income (SSI)? No Ls PERSON 2 receive supplemental Security income (SSI)? No Ls PERSON 2 receive supplemental Security income (SSI)? No Ls PERSON 2 a U.S. citizen or U.S. national? Yes. If yes, skip to Question 14. No Societary of the PERSON 2 enter the U.S.? Societary of U.S. national, please provide the information below. Is PERSON 2 enter the U.S.? Societary of the Federated State of Micronesia, the Republic of the Marshall Islands or Palau? Societary Yes No Ls PERSON 2 in fort a or one of the primary person(s) taking care of a child under age 19 years that lives with you? Yes No Ls PERSON 2 in forter care at age 18 or older in Hawaii? Ne Societary Yes No Societary Conternation (Chicano /a) Puerto Rican Cluban Other	<b>_</b>	U	) –						
b. Has PERSON 2 received long term care nursing services in the last three (3) months? Ves. If yes, what date(s)? Ves. If yes, ves. No Does PERSON 2 receive Supplemental Security Income (SSI)? Yes No No 10. Des PERSON 2 receive any medical services in the past ten (10) calendar days immediately prior to the date of this application? Yes. If yes, what date(s)? Yes. If yes, what is present to use an active-duty member of the U.S. military? Yes. No Is. Is PERSON 2 in foster care at age 18 or older in Hawaii? Yes. No Is. Is PERSON 2 in foster care at age 18 or older in Hawaii? Yes. No Is. Is PERSON 2 in foster care at age 18 or older in Hawaii? Yes. No Is. Race (OPTIONAL – check all that apply.) White Black or African American Chicano/a Puerto Rican Chicano Cher African American Chicano American Indian or Alaska Native National American Indian or Alaska Native National Chicano Pereston 2 on the back Korean Now, tell us about any income from PERSON 2 on the back	10. Does PERSON 2 have a dis	ability that will last more than to	welve (12) months	?	]Yes 🔲 M	lo			_
c. Does PERSON 2 need long term care nursing services now? Yes No   11. Did PERSON 2 receive Supplemental Security Income (SSI)? Yes No   11. Did PERSON 2 receive say medical services in the past ten (10) celendar days immediately prior to the date of this application? No   12. Is PERSON 2 a U.S. citizen or U.S. national? Yes. If yes, skip to Question 14. No   13. If PERSON 2 a U.S. citizen or U.S. national? Yes. If yes, skip to Question 14. No   14. Is PERSON 2 a U.S. citizen or U.S. national. please provide the information below. a. Immigration document type   b. Document ID number   c. When did PERSON 2 enter the U.S.? .   d. Is PERSON 2 a clitzen or the rederated State of Micronesia, the Republic of the Marshall Islands or Palau? Yes   No .   14. Is PERSON 2 the primary or one of the primary person(s) taking care of a child under age 19 years that lives with you? Yes   15. Was PERSON 2 in foster care at age 18 or older in Hawaii? Yes No   16. Is PERSON 2 a full-time student? Yes No   17. If Hippanic/Latino, ethnicity (OPTIONAL—check all that apply.) Mexican, American American Filipino   White Black or African American Filipino Vietnamese   B. Race (OPTIONAL—check all that apply.) White Black or African American   Mexican Mexican Indian or Alaska Native Japanese Other Asian   Asian Indian American Indian or Alaska Native Japanese Other Asian   Chinese Native Hawaian K									
d. Does PERSON 2 receive Supplemental Security Income (SSI)?       Yes       No         11. Did PERSON 2 receive any medical services in the past ten (10) calendar days immediately prior to the date of this application?       Yes. If yes. what date(s)?         12. Is PERSON 2 a U.S. citizen or U.S. national?       Yes. If yes. skip to Question 14.       No         13. If PERSON 2 isn't a U.S. citizen or U.S. national?       Yes. If yes. skip to Question 14.       No         13. If PERSON 2 isn't a U.S. citizen or U.S. national. please provide the information below.       a. Immigration document type						es. If yes, 1	what date(s)? _		0
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13. If PERSON 2 isn't a U.S. oltizen or U.S. national, please provide the information below.         a. Immigration document type	Yes. If yes, what date(s)				No				
a. Immigration document type	12. Is PERSON 2 a U.S. citizen	or U.S. national? 🔲 Yes. I	fyes, skip to Qu	estion 14	1. 🔲 N	0			
b. Document ID number			ovide the informat	on below.					
d. Is PERSON 2 a clitzen of the Federated State of Micronesis, the Republic of the Marshall Islands or Palav? Yes No e. Is PERSON 2 on their spouse or parent, a veteran or an active-duty member of the U.S. military? Yes No 14. Is PERSON 2 the primary or one of the primary person(s) taking care of a child under age 19 years that lives with you? Yes 10. 14. Is PERSON 2 the primary or one of the primary person(s) taking care of a child under age 19 years that lives with you? Yes 10. 15. Was PERSON 2 in foster care at age 19 or older in Hawaii? Yes No 16. Is PERSON 2 a full-time student? Yes No 17. If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply.) Mexican Mexican, American Chicano/a Puerto Rican Cluban Other 18. Rose (OPTIONAL—check all that apply.) 19. White Black or African American Filipino Vietnamese Guamanian or Chamorro 10. White American Indian or Alaska Native Japanese Other Asian Other Action Islander 20. Chinese Notive Hawaiian Now, tell us about any income from PERSON 2 on the back	b. Document ID number								
e. Is PERSON 2, or their spouse or parent, a veteran or an active-duty member of the U.S. military? Yes No 14. Is PERSON 2 the primary or one of the primary person(s) taking care of a child under age 19 years that lives with you? Yes 15. Was PERSON 2 in foster care at age 18 or older in Hawaii? Yes No 16. Is PERSON 2 in foster care at age 18 or older in Hawaii? Yes No 17. If Hispanio/Latino, ethnicity (OPTIONAL - check all that apply.) Mexican. American (and care of A chican American) 18. Race (OPTIONAL - check all that apply.) White Black or African American Anien Indian American Indian or Alaska Native American and Indian or Alaska Native Korean Now, tell us about any income from PERSON 2 on the back			asia the Republic	of the Mor	shell lelends s	r Palau?		No	
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Mexican       Mexican, American       Chicano/a       Puerto Rican       Cuban       Other			poly.)						
White     Black or African American     American Indian or Alaska Native     American Indian or Alaska Native     Chinese     Notive Hawsiian     Now, tell us about any income from PERSON 2 on the back				lican	🔲 Cuban	🔲 Otł	ner		
Asian Indian     American Indian or Alaska Native     Japanese     Other Asian     Other Pacific Islander     Korean     Samoan     Other     Thinsse     Netive Hawaiian     Now, tell us about any income from PERSON 2 on the back	18. Race (OPTIONAL - check a	I that apply.)							_
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	Der 18, 2015		Effe	ctive	Date	Jan	uary 1		4

NECHTEL WITH YOUR APPLICATION? Visit <u>mybenefits.hawaii.gov</u> or call us at 1-877-628-5076. If you need help in a language other than English, call 1-877-628-5076 and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY/TDD users should call 1-855-858-8604. DHS 1100 (FeV. 1014) Pag ••• 1

STEP 2: PERSON 2	
CURRENT Job & Income Information	
Employed       If you're currently employed, tell us about your income. Start with question 19.         Skip to question 28.       Skip to question 28.	1.
CURRENT JOB 1:	
19. Employer name and address 20. Employer phone number	S
21. Wages/tips (before taxes) Hourly Weekly Exerc 2 weeks Twice a month Monthly	Ar
<u></u>	1.
22. Average hours worked each WEEK	
CURRENT JOB 2: (If you have more jobs and need more space, attach another sheet of paper.)	
23. Employer name and address 24. Employer phone number	
25. Wages/tips (before taxes) Hourly Weekly Except 2 weeks Monthly	
28. Average hours worked each WEEK	
27. In the past year, did PERSON 2: Change jobs Stop working Start working fewer hours None of these	
28. If self-employed, answer the following questions: aIype of work b. How much net income (profit once business expenses are paid) will you get form this self-employment this month? \$	
29. OTHER INCOME THIS MONTH: Check all that apply, and give the amount and how often you get it. NOTE: You don't need to tell us about child support or veteran's payment.	
Unemployment  S How often?  Net farming/fishing  How often?	2.
Pensions     Social Security     How often?     Deternative S     How often?     Other income     How often?     Deternative S     How often?	
Retirement accounts     How often? Type:	
Alimony received \$ How often?	
30. DEDUCTIONS: Check all that apply, and give the amount and how often you get it. If PERSON 2 pays for certain things that can be deducted on a federal income tax return, telling us about them could make the cost health coverage a little lower.	PR
NOTE: You shouldn't include a cost that you already considered in your answer to net self-employment (question 28b).	con resp
Alimony paid \$ How often? Other deductions \$ How often?	C4-
Student loan interest \$ How often? Type:	
NET YEARLY INCOME: Complete if PERSON 2 net income changes a lot from month to month.     If you don't except changes to PERSON 2 monthly income, skip to the next section.	
PERSON 2's total income this year PERSON 2's total income next year (if you think it will be different)	
\$ \$	
THANKS! This is all we need to know about PERSON 2.	
If there are no more people to include, skip to next page.	
TN NO: 13-007-MM7 Approval Date	Novembe
NEED HELP WITH YOUR APPLICATION? Visit mybenefits.hawaii.gov or call us at 1-877-628-5076. If you need help in a language other than English, call 1-877-5828-5076 and tell the customer service representative the language you need. We'll get you help at no cost to you. TTYTDD users should call 1-885-888-8804.	2
you neip at no cost to you. ITT/TUD users snould call 1-803-808-8004. DHS 1100 (REV. 10/14) Page 5 of 7	DHS

### Are you or is anyone in your family American Indian or Alaska Native.

Yes. If yes, go to Appendix B. No. If No, skip Step 4.

TEP 3

STEP 4 Your Family's Health Coverage
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swer these questions for anyone who need health coverage

Does anyone have health coverage or health insurance other than Medicaid?

Yes. If yes, check the type of coverage and write the person(s) name(s) on the line provided	and additional information as appropriate.
----------------------------------------------------------------------------------------------	--------------------------------------------

American Indian or Alaska Native (Al/AN) family member(s)

	Employer insurance	-
	Name of health insurance:	-
	Policy number:	-
	Is this COBRA coverage? 🔲 Yes 🔲 No	
	ls this a retiree health plan? 🔲 Yes 🛄 No	
	Medicare	
	TRICARE	-
	(Don't check if you have direct care or Line of Duty)	
	VA health care programs	-
	Peace Corp	-
	Other	-
	Name of health insurance:	-
	Policy number:	-
	Is this a limited-benefit plan (like a school accident policy)?	🔲 Yes
No		

No 🗌

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Is anyone listed on this application offered health coverage from a job?

(Check YES even if the coverage is from someone else's job, such as a parent or spouse.)

🔲 Yes. If yes, you'll need to complete and include Appendix A. Is this a state employee benefit plan? 🔲 Yes 🔲 No

No. If no, continue to Step 5

#### A Disclosure Statement

ording to the Paper work Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB nton in moter for this information collection is 1993-1141. The time required to complete this information collection is estimated to average (Incent Time (hours or minutes)) per ponse, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments remaining the accuracy of the time estimate(s) or suggestion. For more that is from, please withe to: CUAS, 7500 Security Boulevard, Atto: PRA Reports Clearance Offneer, Mail Stop 26-05, Baltimore, Maryland 21244-1850.

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### er 18, 2015

### Effective Date: January 1, 2014

NEED HELP WITH YOUR APPLICATION? Visit mybenefits.hawaii.gov or call us at 1-877-628-5076. If you need help in a language other than English, call 1-877-628-5076 and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY/TDD users should call 1-855-858-8604. DHS 1100 (REV. 10/14)

### **!!!SIGNATURE REOUIRED BELOW!!!**

#### STEP 5 Read and sign this application

- I'm signing this application 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 provide false and/or untrue information
- I understand I must tell the Department of Human Services or the Hawaii Health Connector if anything changes (and is different than) what I wrote on this application. I can visit mybenefits.hawaii.gov or call 1877-628-5076 to report any changes. I understand that a change in my information could affect the eligibility for member(s) of my household
- I understand that under federal law, discrimination isn't permitted on the basis of race, color, national origin, sex, age, sexual orientation gender identity, or disability. I can file a complaint of discrimination by visiting www.hhs.gov/ocr/office/file.
- I understand the Department of Human services and the Hawaii Health Connector will obtain information to verify eligibility with electronic databases. to include but not limited to, the Internal Revenue Services (IRS), Social Security Administration (SSA), Department of Homeland Security (DHS) or a consumer reporting agency. If the information doesn't match, we may ask to you send us proof

#### Renewal of coverage in future years

To make it easier to determine my eligibility for help paying for health coverage in future years, I agree to allow the Hawaii Health Connector to use income data, including information from tax returns. The Hawaii Health Connector will send me a notice, let me make any changes, and I can opt out at any time

#### Yes, renew my eligibility automatically for the next

5 years (the maximum number of years allowed), or for a shorter number of years 4 years 3 years 2 years 1 vears 0

Don't use information from tax returns to renew my coverage.

#### If anyone on this application is eligible for Medicaid.

- · I am assigning the Department of Human Services, my rights to payments for medical care from any third party, which may include but not limited to, other health insurance or legal settlement. I am also assigning the Department of Human Services, my rights to pursue and get medical support from a spouse or parent. I will cooperate in obtaining third party payments.
- Does any child on this application have a parent living outside of the home? 🔲 Yes 🛛 No. If yes, I understand I will be asked to cooperate with the Department of Human Services and the agency that collects medical support form an absent parent. If I think that cooperating to collect medical support will harm me or my children, I can tell Medicaid and I may not have to cooperate.
- I agree to cooperate with the Department of Human Services, Federal Quality Control reviewers or auditors if my case is selected for a review

#### 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 ask for a fair review of the action. 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 information will be explained to me

Sign this application. The person who filled out Step 1 should sign this application. If you're an authorized representative you may sign here with your name, as long as you have provided the information required in Appendix C.

Signature	Date (mm/dd/yyyy)

#### STEP 6 Mail your signed application to:

MQD/EB

MOD/FB Oahu Section P.O. Box 3490 Honolulu, HI 96811-3490

Kapolei Unit P.O. Box 29920 Honolulu, HI 96820-2320

MQD/EB MQD/EB Lanai Unit Maui Section P.O. Box 631374 Millyard Plaza Lanai City, HI 96793-0737 210 Imi Kala Street, Suite 101 Honolulu, HI 96820-2320

TN NO: 13-007-MM7

East Hawaii Section 1404 Kilauea Avenue Hilo, HI 96720 MQD/EB

MQD/EB

Molokai Unit

P.O. Box 1619

Kaunakakai, HI 96748-1619

75-5591 Palani Road, Suite 3004 Kailua-Kona HI 96740-3633 MOD/EB

Kauai Section 4473 Pahee Street, Suite A Lihue, HI 96766

**Approval Date** 

MQD/EB

West Hawaii Section

Lanibau Professional Center

### APPENDIX A

#### Health Coverage from Jobs

You DON'T need to answer these questions unless someone in the household is eligible for health coverage from a job. Attach a copy of this page for each job that offers coverage.

#### Tell us about the job that offers coverage

Take the Employer Coverage Tool on the next page to the employer who offers coverage to help you answer these questions. You only need to include this page when you send in your application, not the Employer Coverage Tool



The employee needs to fill out this section 1. Employee name (First, Middle, Last)

2. Emplo	oyee Social	Security N	lumber	

#### EMPLOYER Information - Is the second se

Ask the employer for this se	cuon.		
3. Employer name		4. Emj	ployer Identification Number (EIN)
5. Employer address (notice will be sent t	o this address)	6. Emj (	ployer phone number ) –
7. City	8. State	9. Zip	Code
10. Who can we contact about employee	health at this job?	L. L	
11. Phone number (if different from above ( ) –	a)	12. Email address	
13. Are you currently eligible for coverage Yes (continue) 13a. If you're in a waiting or prob		, ,	three (3) months?
List the names of anyone else wh Name:	Name:	sjob. Na	
Tell us about the health plan offere			
14. Does the employer offer a health plan	that meets the minimum value s	tandard*?	
15. For the lowest-cost plan that meets th wellness programs, provide the premi programs, and did not receive any oth a. How much would the employee hav b. How often? Weekly Eve	um that the employee would pay er discounts based on wellness re to pay in premiums for this pla	if he/she received the maximum programs. 1? \$	discount for any tobacco cessation
18. What change will the employer make Employer won't offer health covers meets the minimum value standar a. How much will the employee h b. How often?	age. coverage to employees or chang d.*(Premium should reflect the d ave to pay in premiums for that p	scount for wellness programs. S an? \$	_
Date of change (mm/dd/www): "An employer-sponsored health plan meets the "mil 368/cl/2)(Clill) of the internal Revenue Code of 19		the total allowed benefit cost covered by th	ne plan is no less than 60 percent of such costs (Section

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Annendix Page 1 of 4

### November 18, 2015

DHS 1100 (REV. 10/14)

### Effective Date: January 1, 2014

NEED HELP WITH YOUR APPLICATION? Visit mybenefits.hawaii.gov or call us at 1-877-628-5076. If you need help in a language other than English, call 1-877-628-5076 and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY/TDD users should call 1-855-858-8604. DHS 1100 (REV. 10/14) Page 7 of 7

If you want to register to vote you can complete the attached voter registration from or download a form from hawaii.gov/elections.

 NEED HELP WITH YOUR APPLICATION? Visit mybenefits.hawaii.gov or call us at 1-877-628-5076. If you need help in a language other than English, call 1-877-628-5076 and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY/TDD users should call 1-855-858-8604.

### EMPLOYER COVERAGE TOOL

Use this tool to help answer questions in Appendix A about any employer health coverage that you're eligible for (even if it's from another person's job, like a parent or spouse). The information in the numbered boxes below match the boxes on Appendix A. For example, the answer to question 14 on this page should match question 14 on Appendix A.

Write your name and Social Security number in boxes 1 and 2 and ask the employer to fill out the rest of the form. Complete one tool for each employer that offers health coverage.

### EMPLOYEE Information

The employee needs to fill out this section 1. Employee name (First, Middle, Last)

2. Social Security Number

### EMPLOYER Information

Ask the employer for this section.			
3. Employer name			<ol> <li>Employer Identification Number (EIN)</li> </ol>
<ol><li>Employer address (notice will be sent to this a</li></ol>	address)		6. Employer phone number
			( ) -
7. City	8. State		9. Zip Code
10. Who can we contact about employee health	at this job?		•
	-		
11. Phone number (if different from above)		12. Email address	
() -			

13. Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next three (3) months? Yes (continue) 13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage?

mm/dd/vvvv (Continue)

#### No (STOP and return this form to employee)

Tell us about the health plan offered by this employer. Does the employer offer a health plan that covers an employee's spouse or dependent? Yes Which people? Spouse Dependent(s)

Go to question 14)

- 14. Does the employer offer a health plan that meets the minimum value standard*?
- Yes (Go to question 15) INO (STOP and return form to employee)
- 15. For the lowest-cost plan that meets the minimum value standard* offered only to the employee (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/she received the maximum discount for any tobacco cessation programs
- and did not receive any other discounts based on wellness programs.
- a. How much would the employee have to pay in premiums for this plan? \$

b. How often? Weekly Every 2 weeks Twice a month Once a month Quarterly Yearly If the plan year will end soon and you know the health plans offered will change, go to question 10. If you don't know, STOP and return form to

employee.

- 16. What change will the employer make for the new plan year?
- Employer won't offer health coverage.
  Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.*(Premium should reflect the discount for wellness programs. See question 15) a. How much will the employee have to pay in premiums for that plan? \$
- b. How often? Weekly Every 2 weeks Twice a month Once a month Quarterly Yearly
- Date of change (mm/dd/yyyy

An employer-sponsored health plan meets the "minimum value standard" If the plan's share of the total allowed benefit cost covered by the plan is no less than 60 percent of such costs (Section 356(c)(2)(C)(t) of the internal Revenue Code of 1986)

### APPENDIX B

#### American Indian or Alaska Native Family Member (Al/AN)

Complete this appendix if you or a family member are American Indian or Alaska Native. Submit this with your Application for Health Coverage & Help Paying Costs.

Tell us about your American Indian or Alaska Native family member(s)

American Indians and Alaska Natives can get services from the Indian Health Services, tribal health program, or urban Indian health programs. They also may not have to pay cost sharing and may get special monthly enrollment periods. Answer the following questions to make sure your family gets the most help possible.

NOTE: If you have more people to include, make a copy of this page and attach.

	AI/AN PERSON 1	AI/AN PERSON 2
1. Name (First name, Middle name, Last name)	First Middle	First Middle
	Last	Last
2. Member of a federally recognized tribe?	Yes If yes, tribe name is:	Yes If yes, tribe name is:
3. Has this person ever gotten a service from the Indian Health Service, a tribal health program. or urban Indian health program, or through a referral from one of these programs?	No No. If no, is this person eligible to get services from the Indian Health services, tribal health programs, or through a referral from one of these programs? Yes No	No No. If no, is this person eligible to get services from the Indian Health services, tribal health programs, or hough a referral from one of these programs? Yes No
<ol> <li>Certain money received may not be counted for Medical or the Children's Health Insurance Program (CHIP). List any income (amount and how often) reported on your application that includes money from these sources:</li> <li>Per capite payments from a tribe that come from natural resources, usage rights, leases, or royalties.</li> <li>Payments from natural resources, familing, ranching, failing, leases, or royalties from land designated as Indian trust land by the Department of Interior (including reservations and former reservations).</li> <li>Money from selling things that have cultural significance.</li> </ol>	\$ How often?	\$ How often?

NEED HELP WITH YOUR APPLICATION? Visit mybenefits.hawaii.gov or call us at 1-877-628-5076. If you need help in a

NEED HELP WITH YOUR APPLICATION? Visit mybenefits.hawaii.gov or call us at 1-877-628-5076. If you need help in a language other than English, call 1-877-628-5076 and tell the customer service representative the language you need. We'll get DHS 1100/864 10/10 13-007- NTN17/ d call 1-855-858-8604.

language other than English, call 1-877-628-5076 and tell the customer service representative the language you need. We'll get November 18, 2015

Approval Date

··· 1

Assistance with	Completing this Application		
You can choose an a	uthorized representative.		
related to this application, i person is called an "author	including getting information about your applicati	n us, see your information, and act for you on matters ion and signing your application on your behalf. This e your authorized representative, call 1-877-628-5076. If submit proof with the application.	
1. Name of authorized repres	sentative (First name, Middle name, Last name)		
2. Address		3. Apartment or suite number	
4. City	5. State	6. Zip code	
7. Phone number ( ) –			
8. Organization name		9. ID number (if applicable)	
By signing, you allow this matters with this agency. 10. Your signature		mation about this application, and act for you on all future ate (mm/dd/1000)	
matters with this agency. 10. Your signature Authorized Represent As the designated Authoriz Department or tts designe	ative	identiality of any information provided to me by the	
matters with this agency. 10. Your signature Authorized Represent As the designated Authoriz Department or it's designe As applicable, 1 of an organization: I understand and agree, confidentiality of informa or an organization acting		identiality of any information provided to me by the esentiative by signing below:	
matters with this agency. 10. Your signature Authorized Represent As the designated Authoriz Department or it's designe As applicable, I of an organization: I understand and agree, a confidentiality of informer or an organization acting and confidentiality of informer			
matters with this agency. 10. Your signature Authorized Represent As the designated Authoric Department or it's designe As applicable, I of an organization: I understand and agree, confidentiality of informe or an organization acting and confidentiality of informe For certified application	11. Da      ative      ted Representative, I agree to maintain the confi e and I can be released as the Authorized Representative      Signature of Authorized Representative      Street Address      PRINT Name of Individual      PRINT Name of Individual      PRINT Name of Provider/Organization as a condition of serving as the Authorized Representation and the prohibition against reassignmen on the facility's behalf, as well other relevan      ormation.  In counselors, navigators, agents, and to      u're a certified application counselor, navigator,		
matters with this agency. 10. Your signature Authorized Represent As the designated Authoriz Department or it's designe As applicable, 1 of an organization: I understand and agree, a confidentiality of informa or an organization acting and confidentiality of informa For certified applicatio Complete this section if yo	11. Da      ative      red Representative, I agree to maintain the confi e and I can be released as the Authorized Repre      Signature of Authorized Representative      Street Address      PRINT Name of Individual      PRINT Name of Provider/Organization as a condition of serving as the Authorized R      tion and the prohibition against reassignmen     on the facility's behalf, as well other relevan     ormation.  In counselors, navigators, agents, and t      vire a certified application counselor, navigator,     //dd/xxxx)	tee (mmiddlyggg)  identiality of any information provided to me by the esentiality by signing below:  Telephone Date  City State Zip Code  , am a provider or staff member or volunteer  , am a provider or staff member or volunteer  to f provider claims as appropriate for a health facility tt State and Federal laws covering conflicts of interest brokers only.	

TN NO: 13-007-MM7

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# **Med-QUEST Responsibilities**

Upon receipt of the HPE packet sent by the participating hospital, the Med-QUEST office shall:

- Log receipt of HPE packet and input information from HPE application and decision notice into the KOLEA system within 48 hours of receipt;
- Review DHS 1100 and determine eligibility for regular Medicaid or pend for verifications if needed;
- Upon receipt of required verifications, complete eligibility determination for regular Medicaid.
- Send appropriate Medicaid approval or denial notice to HPE beneficiary and a copy to HPE hospital staff who submitted the HPE packet
- Terminate HPE benefits pursuant to hospital PE period from date the eligibility determination for regular Medicaid is determined.
- If an HPE application is received with no DHS 1100 attached, input information in KOLEA, and terminate HPE effective the last day of the month following the month of HPE application.

# **Connecting to Full Medicaid Coverage Outside the Hospital**

Individuals can also apply for full Medicaid coverage as follows:

- Online at mybenefits.Hawaii.gov or by calling 1-877-628-5076;
- In-person at the nearest Med-QUEST Eligibility Branch office;
- By mailing the paper application to the Med-QUEST Eligibility Branch office closest to their home;
- By faxing the paper application to 587-3543; or
- By calling Medicaid customer service on Oahu: 524-3370, TDD: 692-7182, Neighbor Islands : 1-800-316-8005, TDD: 1-800-603-1201
# **Contact Information**

For questions or more information on Hawaii's Hospital Presumptive Eligibility policies, providers may contact:

> Policy and Program Development Office Phone: 808-692-8058, Fax: 808-692-8173

Information is also available on the Department's website:

www.Med-QUEST.us- Program information



OMB Control Number 0938-1148 OMB Expiration date: 10/31/2014

42	CFR 435.110 02(a)(10)(A)(i)(I) 31(b) and (d)	
19	02(a)(10)(A)(i)(I)	$\mathbf{N}$
19	31(b) and (d)	

Parents below a	and stand	Other Caretaker Relatives - Parents and other caretaker relatives of dependent children with household income at ard established by the state.
🛛 The	state	attests that it operates this eligibility group in accordance with the following provisions:
	Indi	viduals qualifying under this eligibility group must meet the following criteria:
		Are parents or other caretaker relatives (defined at 42 CFR 435.4), including pregnant women, of dependent childred (defined at 42 CFR 435.4) under age 18. Spouses of parents and other caretaker relatives are also included.
		The state elects the following options:
		This eligibility group includes individuals who are parents or other caretakers of children who are 18 years old, provided the children are full-time students in a secondary school or the equivalent level of vocational or technical training.
		Options relating to the definition of caretaker relative (select any that apply):
		The definition of caretaker relative includes the domestic partner of the parent or other caretaker relative, even after the partnership is terminated.
		Definition of domestic partner:
		The definition of caretaker relative includes other relatives of the child based on blood (including those of half-blood), adoption or marriage.
		Description of other relatives:
		The definition of caretaker relative includes any adult with whom the child is living and who assumes primary responsibility for the dependent child's care.
		Options relating to the definition of dependent child (select the one that applies):
		The state elects to eliminate the requirement that a dependent child must be deprived of parental support o care by reason of the death, physical or mental incapacity, or absence from the home or unemployment of least one parent.
	below a	below a stands

O The child must be deprived of parental support or care, but a less restrictive standard is used to measure unemployment of the parent (select the one that applies):

C.	Medicaid Eligibility
1	Have household income at or below the standard established by the state.
	MAGI-based income methodologies are used in calculating household income. Please refer as necessary to S10 MAGI- Based Income Methodologies, completed by the state.
	Income standard used for this group
	Minimum income standard
•	The minimum income standard used for this group is the state's AFDC payment standard in effect as of May 1, 1988, converted to MAGI-equivalent amounts by household size. The standard is described in S14 AFDC Income Standards.
	The state certifies that it has submitted and received approval for its converted May 1, 1988 AFDC payment standard.
	Maximum income standard
	The state certifies that it has submitted and received approval for its converted income standard(s) for parents and other caretaker relatives to MAGI-equivalent standards and the determination of the maximum income standard to be used for parents and other caretaker relatives under this eligibility group.
	The state's maximum income standard for this eligibility group is:
	O The state's effective income level for section 1931 families under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL or amounts by household size.
	<ul> <li>The state's effective income level for section 1931 families under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL or amounts by household size.</li> </ul>
	The state's effective income level for any population of parents/caretaker relatives under a Medicaid 1115 O demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL or amounts by household size.
	The state's effective income level for any population of parents/caretaker relatives under a Medicaid 1115 O demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL or amounts by household size.
	Enter the amount of the maximum income standard:

	Medicaid Eligibility
	• A percentage of the federal poverty level: 100 %
	C The state's AFDC payment standard in effect as of July 16, 1996, converted to a MAGI-equivalent standard. The standard is described in S14 AFDC Income Standards.
	The state's AFDC payment standard in effect as of July 16, 1996, increased by no more than the percentage increase in the Consumer Price Index for urban consumers (CPI-U) since such date, converted to a MAGI- equivalent standard. The standard is described in S14 AFDC Income Standards.
	O The state's TANF payment standard, converted to a MAGI-equivalent standard. The standard is described in S14 AFDC Income Standards.
de te	O Other dollar amount
	Income standard chosen:
	Indicate the state's income standard used for this eligibility group:
	O The minimum income standard
	• The maximum income standard
	The state's AFDC payment standard in effect as of July 16, 1996, increased by no more than the percentage increase in the Consumer Price Index for urban consumers (CPI-U) since such date. The standard is described in S14 AFDC Income Standards.
10.00	O Another income standard in-between the minimum and maximum standards allowed
1 0	There is no resource test for this eligibility group.
	Presumptive Eligibility
	The state covers individuals under this group when determined presumptively eligible by a qualified entity. The state assure it also covers individuals under the Pregnant Women (42 CFR 435.116) and/or Infants and Children under Age 19 (42 CFR 435.118) eligibility groups when determined presumptively eligible.
	O Yes  No

### PRA Disclosure Statement



OMB Control Number 0938-1148 OMB Expiration date: 10/31/2014

2 CFR 435.116 902(a)(10)(A)(i)(III) and (IV)		
902(a)(10)(A)(ii)(I), (IV) and (IX)		
931(b) and (d) 920		
Pregnant Women - Women w	o are pregnant or post-partum, with househo	ld income at or below a standard established by the state.
	tes this eligibility group in accordance with	
		or post-partum, as defined in 42 CFR 435.4.
Pregnant women in the group in accordance we Caretaker Relatives at	ith section 1931 of the Act, if they meet the	pendent children are eligible for full benefits under this income standard for state plan Parents and Other
O Yes 💿 No		
MAGI-based income n Income Methodologies	ethodologies are used in calculating househ , completed by the state.	old income. Please refer as necessary to S10 MAGI-Based
Income standard used	or this group	
Minimum income	standard (Once entered and approved by CM	AS, the minimum income standard cannot be changed.)
The state had an i eligibility for pre-	ncome standard higher than 133% FPL estab mant women, or as of July 1, 1989, had auth	blished as of December 19, 1989 for determining orizing legislation to do so.
• Yes O No		
Enter the am	ount of the minimum income standard (no h	igher than 185% FPL): 185 % FPL
Maximum income	standard	
women to MA	fies that it has submitted and received appro GI-equivalent standards and the determinati en under this eligibility group.	val for its converted income standard(s) for pregnant ion of the maximum income standard to be used for
	a in an	
The state's maxim	um income standard for this eligibility grou	ıp is:
families), 19 related pregn (A)(ii)(I) (pro- (institutional)	2(a)(10)(A)(i)(III) (qualified pregnant wom ant women), 1902(a)(10)(A)(ii)(IX) (options gnant women who meet AFDC financial eli	Pregnant women under sections 1931 (low-income en), 1902(a)(10)(A)(i)(IV) (mandatory poverty level- al poverty level-related pregnant women), 1902(a)(10) igibility criteria) and 1902(a)(10)(A)(ii)(IV) edicaid state plan as of March 23, 2010, converted to a

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i an	-		-	
-	- Ser		137	
128	1 Bent		1	-
	A. Sec.	1 1	1000	1

	۲	The state's highest effective income level for coverage of pregnant women under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified pregnant women), 1902(a)(10)(A)(i)(IV) (mandatory poverty level-related pregnant women), 1902(a)(10)(A)(ii)(IX) (optional poverty level-related pregnant women), 1902(a)(10)(A)(ii)(IX) (optional poverty level-related pregnant women), 1902(a)(10)(A)(ii)(IV) (A)(ii)(IV) (institutionalized pregnant women) in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.
	0	The state's effective income level for any population of pregnant women under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.
	0	The state's effective income level for any population of pregnant women under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.
	0	185% FPL
		The amount of the maximum income standard is: 191 % FPL
	Inco	me standard chosen
	Ind	icate the state's income standard used for this eligibility group:
	0	The minimum income standard
R 42	۲	The maximum income standard
	0	Another income standard in-between the minimum and maximum standards allowed.
T T	here is	no resource test for this eligibility group.
B	enefits	for individuals in this eligibility group consist of the following:
(		pregnant women eligible under this group receive full Medicaid coverage under this state plan.
(	O Preg	mant women whose income exceeds the income limit specified below for full coverage of pregnant women receive pregnancy-related services.
P	resump	tive Eligibility
		te covers ambulatory prenatal care for individuals under this group when determined presumptively eligible by a d entity.
- (	O Yes	No No

### PRA Disclosure Statement



OMB Control Number 0938-1148 OMB Expiration date: 10/31/2014

1902(a)(10)(A 1931(b) and (	A)(i)(III), (IV), (VI) and (VII) A)(ii)(IV) and (IX) d)
Infants a the state b	nd Children under Age 19 - Infants and children under age 19 with household income at or below standards established by pased on age group.
The s	state attests that it operates this eligibility group in accordance with the following provisions:
	Children qualifying under this eligibility group must meet the following criteria:
	Are under age 19
	Have household income at or below the standard established by the state.
	MAGI-based income methodologies are used in calculating household income. Please refer as necessary to S10 MAGI- Based Income Methodologies, completed by the state.
	Income standard used for infants under age one
	Minimum income standard
	The state had an income standard higher than 133% FPL established as of December 19, 1989 for determining eligibility for infants under age one, or as of July 1, 1989, had authorizing legislation to do so.
	• Yes O No
	Enter the amount of the minimum income standard (no higher than 185% FPL): 185 % FPL
	Maximum income standard
	The state certifies that it has submitted and received approval for its converted income standard(s) for infants I under age one to MAGI-equivalent standards and the determination of the maximum income standard to be used for infants under age one.
	and the second dependence of the second s
	The state's maximum income standard for this age group is:
	The state's highest effective income level for coverage of infants under age one under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(IV) (mandatory poverty level-related infants), 1902(a)(10)(A)(ii)(IX) (optional poverty level-related infants) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

Approval Date: 09/13/2013 S30-1

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	The state's highest effective income level for coverage of infants under age one under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(IV) (mandatory poverty level-related infants), 1902(a)(10)(A)(ii)(IX) (optional poverty level-related infants) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.
	O The state's effective income level for any population of infants under age one under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.
	O The state's effective income level for any population of infants under age one under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.
· ·	O 185% FPL
	Enter the amount of the maximum income standard: 191 % FPL
۵	Income standard chosen
	The state's income standard used for infants under age one is:
	• The maximum income standard
	If not chosen as the maximum income standard, the state's highest effective income level for coverage of infants under age one under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10) (A)(i)(IV) (mandatory poverty level-related infants), 1902(a)(10)(A)(ii)(IX) (optional poverty level-related infants) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.
	If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's highest effective income level for coverage of infants under age one under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10) (A)(i)(IV) (mandatory poverty level-related infants), 1902(a)(10)(A)(ii)(IX) (optional poverty level-related infants) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.
	If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's effective income level for any population of infants under age one under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.
	If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's effective income level for any population of infants under age one under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.
	Another income standard in-between the minimum and maximum standards allowed, provided it is higher than the effective income standard for this age group in the state plan as of March 23, 2010.
	ncome standard for children age one through age five, inclusive
	Minimum income standard

Sile	Medicaid Eligibility
	The minimum income standard used for this age group is 133% FPL.
	Maximum income standard
	The state certifies that it has submitted and received approval for its converted income standard(s) for children age one through five to MAGI-equivalent standards and the determination of the maximum income standard to be used for children age one through five.
	The state's maximum income standard for children age one through five is:
	The state's highest effective income level for coverage of children age one through five under sections 1931 (low income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(VI) (mandatory poverty level-related children age one through five), and 1902(a)(10)(A)(i)(IV) (institutionalized children), in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.
	<ul> <li>The state's highest effective income level for coverage of children age one through five under sections 1931 (low income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(VI) (mandatory poverty level-related children age one through five), and 1902(a)(10)(A)(i)(IV) (institutionalized children), in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.</li> </ul>
	O The state's effective income level for any population of children age one through five under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.
	O The state's effective income level for any population of children age one through five under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.
	Enter the amount of the maximum income standard: [139] % FPL
	Income standard chosen
	The state's income standard used for children age one through five is:
	The maximum income standard
	If not chosen as the maximum income standard, the state's highest effective income level for coverage of children age one through five under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(VI) (mandatory poverty level-related children age one through five), and 1902(a)(10)(A)(ii) (IV) (institutionalized children), in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.
	If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, an if not chosen as the maximum income standard, the state's highest effective income level for coverage of children age one through five under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(VI) (mandatory poverty level-related children age one through five), and 1902(a)(10)(A)(i)(VI) (institutionalized children), in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.



	If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's effective income level for any population of children age one through five under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI- equivalent percent of FPL.
	If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's effective income level for any population of children age one through five under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI- equivalent percent of FPL.
	Another income standard in-between the minimum and maximum standards allowed, provided it is higher than the effective income standard for this age group in the state plan as of March 23, 2010.
🔳 In	come standard for children age six through age eighteen, inclusive
	Minimum income standard
	The minimum income standard used for this age group is 133% FPL.
	Maximum income standard
	The state certifies that it has submitted and received approval for its converted income standard(s) for children age six through eighteen to MAGI-equivalent standards and the determination of the maximum income standard to be used for children age six through age eighteen.
	The state's maximum income standard for children age six through eighteen is:
	The state's highest effective income level for coverage of children age six through eighteen under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(VII) (mandatory poverty level-related children age six through eighteen) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.
	The state's highest effective income level for coverage of children age six through eighteen under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(VII) (mandatory poverty level-related children age six through eighteen) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.
	O The state's effective income level for any population of children age six through eighteen under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.
	O The state's effective income level for any population of children age six through eighteen under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.
	● 133% FPL
	Income standard chosen
	The state's income standard used for children age six through eighteen is:

Medicaid Eligibility
 The maximum income standard
If not chosen as the maximum income standard, the state's highest effective income level for coverage of children age six through eighteen under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(VII) (mandatory poverty level-related children age six through eighteen) and 1902(a)(10)(A) (ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.
If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's highest effective income level for coverage of children age six through eighteen under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(VII) (mandatory poverty level-related children age six through eighteen) and 1902(a)(10)(A) (ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.
If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's effective income level for any population of children age six through eighteen under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI- equivalent percent of FPL.
If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's effective income level for any population of children age six through eighteen under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI- equivalent percent of FPL.
Another income standard in-between the minimum and maximum standards allowed, provided it is higher than the effective income standard for this age group in the state plan as of March 23, 2010.
There is no resource test for this eligibility group.
Presumptive Eligibility
The state covers children when determined presumptively eligible by a qualified entity.
O Yes O No

### PRA Disclosure Statement



OMB Control Number 0938-1148 OMB Expiration date: 10/31/2014

#### 1902(a)(10)(A)(i)(VIII) 42 CFR 435.119

The state covers the Adult Group as described at 42 CFR 435.119.

~	**	<b>A</b> 3.7	
•	Yes	O No	
-	1.00	U	

- Adult Group Non-pregnant individuals age 19 through 64, not otherwise mandatorily eligible, with income at or below 133% FPL.
  - The state attests that it operates this eligibility group in accordance with the following provisions:
    - Individuals qualifying under this eligibility group must meet the following criteria:
      - Have attained age 19 but not age 65.
      - Are not pregnant.
      - Are not entitled to or enrolled for Part A or B Medicare benefits.
      - Are not otherwise eligible for and enrolled for mandatory coverage under the state plan in accordance with 42 CFR 435, subpart B.

Note: In 209(b) states, individuals receiving SSI or deemed to be receiving SSI who do not qualify for mandatory Medicaid eligibility due to more restrictive requirements may qualify for this eligibility group if otherwise eligible.

- Have household income at or below 133% FPL.
- MAGI-based income methodologies are used in calculating household income. Please refer as necessary to S10 MAGI-Based Income Methodologies, completed by the state.
- There is no resource test for this eligibility group.

Parents or other caretaker relatives living with a child under the age specified below are not covered unless the child is receiving benefits under Medicaid, CHIP or through the Exchange, or otherwise enrolled in minimum essential coverage, as defined in 42 CFR 435.4.

OUnder age 19, or

- A higher age of children, if any, covered under 42 CFR 435.222 on March 23, 2010:
  - O Under age 20
  - OUnder age 21

Presumptive Eligibility

The state covers individuals under this group when determined presumptively eligible by a qualified entity. The state assures it also covers individuals under the Pregnant Women (42 CFR 435.116) and/or Infants and Children under Age 19 (42 CFR 435.118) eligibility groups when determined presumptively eligible.

🔿 Yes 💿 No

TN No: 13-0007-MM1 Hawaii



#### PRA Disclosure Statement



OMB Control Number 0938-1148 OMB Expiration date: 10/31/2014

2 CFR 435.1 902(a)(10)(4	
Former lin foster of	Foster Care Children - Individuals under the age of 26, not otherwise mandatorily eligible, who were on Medicaid and care when they turned age 18 or aged out of foster care.
The s	state attests that it operates this eligibility group under the following provisions:
	Individuals qualifying under this eligibility group must meet the following criteria:
	Are under age 26.
	Are not otherwise eligible for and enrolled for mandatory coverage under the state plan, except that eligibility under this group takes precedence over eligibility under the Adult Group.
	Were in foster care under the responsibility of the state or Tribe and were enrolled in Medicaid under the state's state plan or 1115 demonstration when they turned 18 or at the time of aging out of that state's or Tribe's foster care program.
	The state elects to cover children who were in foster care and on Medicaid in any state at the time they turned 18 or aged out of the foster care system.
	OYes  No
it al	state covers individuals under this group when determined presumptively eligible by a qualified entity. The state assures so covers individuals under the Pregnant Women (42 CFR 435.116) and/or Infants and Children under Age 19 (42 CFR .118) eligibility groups when determined presumptively eligible.
03	Yes ONo

### PRA Disclosure Statement



OMB Control Number 0938-1148 OMB Expiration date: 10/31/2014

#### 1902(a)(10)(A)(ii)(XX) 1902(hh) 42 CFR 435.218

Individuals above 133% FPL - The state elects to cover individuals under 65, not otherwise mandatorily or optionally eligible, with income above 133% FPL and at or below a standard established by the state and in accordance with provisions described at 42 CFR 435.218.

O Yes O No

#### PRA Disclosure Statement



OMB Control Number 0938-1148 OMB Expiration date: 10/31/2014

#### 42 CFR 435.220 1902(a)(10)(A)(ii)(I)

Optional Coverage of Parents and Other Caretaker Relatives - The state elects to cover individuals qualifying as parents or other caretaker relatives who are not mandatorily eligible and who have income at or below a standard established by the state and in accordance with provisions described at 42 CFR 435.220.

#### • Yes O No

[7] The state attests that it operates this eligibility group in accordance with the following provisions:

Individuals qualifying under this eligibility group must meet the following criteria:

Would be eligible under the state plan for the mandatory eligibility group, Parents and Other Caretaker Relatives, except for income.

Have household income at or below the standard established by the state.

MAGI-based income methodologies are used in calculating household income. Please refer as necessary to S10 MAGI-Based Income Methodologies, completed by the state.

Income standard used for this group

The state covered this optional eligibility group under its state plan as of March 23, 2010, December 31, 2013, or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013.

• Yes O No

Minimum income standard

The income standard used for this eligibility group must exceed the income standard established for the mandatory Parents and Other Caretaker Relatives eligibility group (42 CFR 435.110). Please refer as necessary to S25 Parents and Other Caretaker Relatives for the income standard chosen for that group.

- Maximum income standard
  - The state certifies that it has submitted and received approval for its converted income standard(s) for optionally eligible parents and other caretaker relatives to MAGI-equivalent standards and the determination of the maximum income standard to be used for parents and other caretaker relatives under this eligibility group.

The state's maximum income standard for this eligibility group is:

O The state's effective income level for optionally eligible parents and other caretaker relatives under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL or amounts by household size.

The state's effective income level for optionally eligible parents and other caretaker relatives under the Medicaid O state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL or amounts by household size.

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The state's effective income level for any population of parents/caretaker relatives under a Medicaid 1115 (a) demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL or amounts by household size.

The state's effective income level for any population of parents/caretaker relatives under a Medicaid 1115 O demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL or amounts by household size.

Enter the amount of the maximum income standard:

•A percentage of the federal poverty level:

The state's AFDC payment standard in effect as of July 16, 1996, converted to a MAGI-equivalent
 O standard. If this standard has not been completed in S14 AFDC Income Standards, complete and submit it with this eligibility group. If it has already been completed, refer to it as necessary.

200

%

The state's TANF payment standard, converted to a MAGI-equivalent standard. If this standard has not O been completed in S14 AFDC Income Standards, complete and submit it with this eligibility group. If it has already been completed, refer to it as necessary.

O Other dollar amount

Income standard chosen

Indicate the state's income standard used for this eligibility group:

O The maximum income standard

Another income standard in-between the minimum and maximum standards allowed.

The state's AFDC payment standard in effect as of July 16, 1996, not converted to a MAGI-equivalent O standard. If this standard has not been completed in S14 AFDC Income Standards, complete and submit it with this eligibility group. If it has already been completed, refer to it as necessary.

The state's TANF payment standard, not converted to a MAGI-equivalent standard. If this standard has not O been completed in S14 AFDC Income Standards, complete and submit it with this eligibility group. If it has already been completed, refer to it as necessary.

If not chosen as the maximum income standard, the state's AFDC payment standard in effect as of July 16, 1996, converted to a MAGI-equivalent standard. If this standard has not been completed in S14 AFDC

O Income Standards, complete and submit it with this eligibility group. If it has already been completed, refer to it as necessary.

If not chosen as the maximum income standard, the state's TANF payment standard, converted to a MAGI-Oequivalent standard. If this standard has not been completed in S14 AFDC Income Standards, complete and submit it with this eligibility group. If it has already been completed, refer to it as necessary.

%

Other income standard in-between the minimum and the maximum standards allowed.

The amount of the income standard for this eligibility group is:

• A percentage of the federal poverty level: 105

$\bigcirc$	Other	dollar	amount
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There is no resource test for this eligibility group.



#### PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Approval Date: 09/13/2013 S51-3



### OMB Control Number 0938-1148 OMB Expiration date: 10/31/2014

\$52

### Eligibility Groups - Options for Coverage Reasonable Classification of Individuals under Age 21

42 CFR 435.222 1902(a)(10)(A)(ii)(I) 1902(a)(10)(A)(ii)(IV)

**Reasonable Classification of Individuals under Age 21** - The state elects to cover one or more reasonable classifications of individuals under age 21 who are not mandatorily eligible and who have income at or below a standard established by the state and in accordance with provisions described at 42 CFR 435.222.

• Yes O No

The state attests that it operates this eligibility group in accordance with the following provisions:

Individuals qualifying under this eligibility group must qualify under a reasonable classification by meeting the following criteria:

Be under age 21, or a lower age, as defined within the reasonable classification.

Have household income at or below the standard established by the state, if the state has an income standard for the reasonable classification.

Not be eligible and enrolled for mandatory coverage under the state plan.

MAGI-based income methodologies are used in calculating household income. Please refer as necessary to S10 MAGI-Based Income Methodologies, completed by the state.

The state covered at least one reasonable classification under this eligibility group under its Medicaid state plan as of December 31, 2013, or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013, with income standards higher (including disregarding all income) than the current mandatory income standards for the individual's age.

• Yes O No

The state also covered at least one reasonable classification under this group in the Medicaid state plan as of March 23, 2010 with income standards higher (including disregarding all income) than the current mandatory income standards for the individual's age.

O Yes O No

Reasonable Classifications Previously Covered

The state elects the option to include in this eligibility group reasonable classifications that were covered under the Medicaid state plan as of December 31, 2013, or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013.

• Yes O No

The state covers all children under a specified age limit, no higher than any age limit and/or income standard covered in the state plan as of December 31, 2013 or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013, provided the income standard is higher than the current mandatory income standard for the individual's age. Higher income standards may include the disregard of all income.

O Yes O No



The state covers reasonable classifications of children that were covered under the Medicaid state plan as of December 31, 2013 or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013 with an income standard higher than the current mandatory income standard for the age group.

• Yes • No

The previously covered reasonable classifications to be included are:

Previously Covered Reasonable Classifications Included

**Reasonable Classifications of Children** 

Individuals for whom public agencies are assuming full or partial financial responsibility.

Individuals in adoptions subsidized in full or part by a public agency

Individuals in nursing facilities, if nursing facility services are provided under this plan

Individuals receiving active treatment as inpatients in psychiatric facilities or programs, if such services are provided under this plan

Other reasonable classifications

Name of	classification	Description	Age Limit	
+ Section 2101 Children	l(f) - Like	2101(f)-Like Children: Children under age 19 years who were enrolled in Medicaid on December 31, 2013 and would otherwise become ineligible for Medicaid at their first determination using Modified Adjusted Gross Income (MAGI) based methodologies solely due to the loss of income disregards will remain Medicaid eligible until their next redetermination using MAGI methodologies.	Under age 19	X

Enter the income standard used for these classifications (which may be no higher than the highest standard used in the Medicaid state plan as of December 31, 2013 or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013).

Click here once \$11 form above is complete to view the income standards form.

### Section 2101(f) of ACA

Income standard used

Minimum income standard

The minimum income standard for this classification of children must exceed the lowest income standard chosen for children under this age under the Infants and Children under Age 19 eligibility group.

Maximum income standard

**S11** 



No income test was used (all income was disregarded) for this classification either in the Medicaid state plan as of December 31, 2013, or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013.

• Yes • No

The state's maximum standard for this classification of children is no income test (all income is disregarded).

Income standard chosen

Individuals qualify under this classification under the following income standard:

• This classification does not use an income test (all income is disregarded).

• Another income standard higher than the minimum income standard.

New reasonable classifications covered

If the state has not elected to cover the Adult Group (42 CFR 435.119), it may elect to cover additional new age groups or reasonable classifications that have not been covered previously. If the state covers the Adult Group, this additional option is not available, as the standard for the new age groups or classifications is lower than that used for mandatory coverage.

The state does <u>not</u> cover the Adult Group and elects the option to include in this eligibility group additional age groups or reasonable classifications that have not been covered previously in the state plan or under a Medicaid 1115 Demonstration. Any additional age groups or reasonable classifications not previously covered are restricted to the AFDC income standard from July 16, 1996, not converted to a MAGI-equivalent standard.

O Yes 💿 No

There is no resource test for this eligibility group.

### PRA Disclosure Statement



OMB Control Number 0938-1148 OMB Expiration date: 10/31/2014

2 CFR 435.227 902(a)(10)(A)(ii)(	VIII)	
doption assistance	a IV-E Adoption Assistance - The state elects to cover children with special needs agreement in effect with a state, who were eligible for Medicaid, or who had incon state and in accordance with provisions described at 42 CFR 435.227.	for whom there is a non IV-E ne at or below a standard
Yes O No		
The state a	attests that it operates this eligibility group in accordance with the following provisi	ons:
Indivi	duals qualifying under this eligibility group must meet the following criteria:	
	he state adoption agency has determined that they cannot be placed without Medica eeds for medical or rehabilitative care;	id coverage because of special
<b>A</b>	re under the following age (see the Guidance for restrictions on the selection of an	age):
(	Under age 21	
(	) Under age 20	
(	) Under age 19	
(	Under age 18	500 ₀₀
	I-based income methodologies are used in calculating household income. Please re I Income Methodologies, completed by the state.	fer as necessary to S10 MAGI-
	covered this eligibility group in the Medicaid state plan as of December 31, 2013, o ation as of March 23, 2010 or December 31, 2013.	r under a Medicaid 1115
• Yes	O No	
The st	tate also covered this eligibility group in the Medicaid state plan as of March 23, 20	)10.
• Y	es O No	
D	Individuals qualify under this eligibility group if they were eligible under the st the execution of the adoption agreement.	ate's approved state plan prior to
85	the state used an income standard or disregarded all income for this eligibility groups of March 23, 2010 or December 31, 2013, or under a Medicaid 1115 Demonstration December 31, 2013.	p either in the Medicaid state p on as of March 23, 2010 or
(	🔿 Yes 💿 No	
Thomas Thomas	is no resource test for this eligibility group.	

#### PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

TN No: 13-0007-MM1 Hawaii



OMB Control Number 0938-1148 OMB Expiration date: 10/31/2014

1902(a)(10)(A)(ii)(XIV) 42 CFR 435.229 and 435.4 1905(u)(2)(B)

**Optional Targeted Low Income Children** - The state elects to cover uninsured children who meet the definition of optional targeted low income children at 42 CFR 435.4, who have household income at or below a standard established by the state and in accordance with provisions described at 42 CFR 435.229.

• Yes O No.

I The state attests that it operates this eligibility group in accordance with the following provisions:

Individuals qualifying under this eligibility group must not be eligible for Medicaid under any mandatory eligibility group.

MAGI-based income methodologies are used in calculating household income. Please refer as necessary to S10 MAGI-Based Income Methodologies, completed by the state.

The state covered this eligibility group in the state plan as of December 31, 2013, or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013.

• Yes O No

The state also covered this eligibility group in the state plan as of March 23, 2010.

• Yes O No

Until October 1, 2019, states must include at least those individuals covered as of March 23, 2010, but may cover additional individuals. Effective October 1, 2019, states may reduce or eliminate coverage for this group.

Individuals are covered under this eligibility group, as follows:

• All children under age 18 or 19 are covered:

O Under age 19

O Under age 18

O The reasonable classification of children covered is:

Income standard used for this classification

Minimum income standard

The income standard for this classification of children must exceed the lowest income standard chosen for children in the age group selected above, under the mandatory Infants and Children under Age 19 eligibility group.

Maximum income standard

Approval Date: 09/13/2013 \$54-1



The state certifies that it has submitted and received approval for its converted income standard(s) for this classification of children to MAGI-equivalent standards and the determination of the maximum income standard to be used for this classification of children under this eligibility group.

The state's maximum income standard for this classification of children (which must exceed the

O The state's effective income level for this classification of children under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

• The state's effective income level for this classification of children under the Medicaid State Plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

The state's effective income level for this classification of children under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

O The state's effective income level for this classification of children under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

O 200% FPL.

O A percentage of the FPL which may exceed the Medicaid Applicable Income Level, defined in section 2110(b)(4) of the Act, but by no more than 50 percentage points.

The state's maximum income standard for this classification of children (which must exceed the minimum for the classification) is:

308 % FPL

minimum for the classification) is:

Income standard chosen, which must exceed the minimum income standard

Individuals qualify under the following income standard:

• The maximum income standard.

O The state's effective income level for this eligibility group under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

If higher than the effective income level used under the state plan as of March 23, 2010, the state's effective O income level for this eligibility group under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

If higher than the effective income level used under the state plan as of March 23, 2010, the state's effective O income level for this eligibility group under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

If higher than the effective income level used under the state plan as of March 23, 2010, the state's effective O income level for this eligibility group under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

O If higher than the effective income level used under the state plan as of March 23, 2010, 200% FPL.



If higher than the effective income level used under the state plan as of March 23, 2010, a percentage of the O FPL which may exceed the Medicaid Applicable Income Level, defined in section 2110(b)(4) of the Act, but by no more than 50 percentage points.

Another income standard in-between the minimum and maximum standards allowed, provided it is higher than the effective income level for this eligibility group in the state plan as of March 23, 2010.

The income standard for this eligibility group is: 308 % FPL

There is no resource test for this eligibility group.

Presumptive Eligibility

Presumptive eligibility for this group depends upon the selection of presumptive eligibility for the Infants and Children under Age 19 eligibility group. If presumptive eligibility is done for that group, it is done for this group under the same provisions.

### PRA Disclosure Statement



OMB Control Number 0938-1148 OMB Expiration date: 10/31/2014

#### 1902(a)(10)(A)(ii)(XII) 1902(z)

Individuals with Tuberculosis - The state elects to cover individuals infected with tuberculosis who have income at or below a standard established by the state, limited to tuberculosis-related services. O Yes 💿 No

### PRA Disclosure Statement

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Approval Date: 09/13/2013 S55-1



OMB Control Number 0938-1148 OMB Expiration date: 10/31/2014

#### 42 CFR 435.226 1902(a)(10)(A)(ii)(XVII)

Independent Foster Care Adolescents - The state elects to cover individuals under an age specified by the state, less than age 21, who were in state-sponsored foster care on their 18th birthday and who meet the income standard established by the state and in accordance with the provisions described at 42 CFR 435.226.

O Yes 
No

### PRA Disclosure Statement



OMB Control Number 0938-1148 OMB Expiration date: 10/31/2014

#### 1902(a)(10)(A)(ii)(XXI) 42 CFR 435.214

Individuals Eligible for Family Planning Services - The state elects to cover individuals who are not pregnant, and have household income at or below a standard established by the state, whose coverage is limited to family planning and related services and in accordance with provisions described at 42 CFR 435.214.

O Yes O No

### PRA Disclosure Statement

ATTACHMENT 2

### El: converted thresholds daté: 09-APR-2013

opulation/type	applicant type	citiation	size	original standard	converted standard
amily - 1988	applicant	APDC 5/1/1988	1	the second se	\$493
amily - 1960			2 .		\$653
			3		\$795
			4	\$501	\$938
			5	\$689	\$1,083
en de Sante das			6		\$1,232
			7		\$1,391
			No. of Concession, name		\$1,508
			8	The second se	
and the second s		and a second	9	\$1,000	61,623
		and the second sec	10	\$1,059	\$1,739
the second second second second	and the second s		11	1\$1,119	\$1,857
- to an and the second s			12	\$1,179	\$1,974
and the second			13	\$1,239	\$2,091
			14	\$1,299	82,208
			15	\$1,359	\$2,325
	4	and a second sec			8110
			addon	\$60	
the second s	ben 4 months	AFDC 5/1/1988	1	\$327	\$397
			2	\$430	\$524
			3	\$515	\$633
			4	\$601	\$744
1 1/2 ······			5	\$689	\$856
			6	\$780	\$971
	and the second se		the second s	\$882	\$1,097
	Second Second Second	and the second s	7		\$1,181
and the second s	and the second		8	\$942	
and the second se			9	\$1,000	\$1,263
			10	\$1,059	\$1,347
the second s		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	11	\$1,119	\$1,431
			12	\$1,179	\$1,515
			13	\$1,239	\$1,599
		and the second s		\$1,299	\$1,683
			14		\$1,767
a star and a star a			15	\$1,359	
and a second			adáon	\$60	\$81
	her's months	AFDC 5/1/1988	1	\$327	\$388
and the second se	ben 8 months		2	\$430	\$512
and the second state of th			3	0515	\$618
			4	\$601	\$725
			Statement of the local division of the local	\$689	\$834
			5		\$947
	and the second		6	\$780	
and the second se	the second s		7	6882	\$1,070
	1. A.		8	\$942	\$1,151
			9	\$1,000	\$1,230
			10	\$1,059	\$1,310
			11	\$1,119	\$1,391
				\$1,179	\$1,472
			12		
and the second se			13	\$1,239	\$1,553
			14	\$1,299	\$1,634
and the second s			15	\$1,359	\$1,715
		The second s	addon		\$78
and the second second	and the second second	1100 7/16/1004	1	\$418	\$630
Family - 1996	applicant	AFDC 7/16/1996	2	\$565	\$851
The Charge is at the second second	22 July 11 12	and the second se			\$1,071
	4		3	\$712	
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		10 A. 10 A	4	\$859	\$1,291
			5	\$1,006	\$1,511
· · · · · · · · · · · · · · · · · · ·			6	\$1,153	\$1,732
- marine and the second	the second s		7	\$1,300	\$1,952
			8	\$1,446	\$2,171
			9	\$1,593	\$2,392
	and the second			\$1,740	\$2,612
			10		\$2,832
			11	\$1,887	
			12	\$2,034	\$3,052
			13	\$2,181	\$3,273
			14	\$2,328	\$3,493
And the second second			15	\$2,475	\$3,713
	the second second		the second se		\$210
		11 (14 (14 (14 (14 (14 (14 (14 (14 (14 (	addo		
	ben 4 months	AFDC 7/16/1996	*1	\$418	\$479
			2	\$565	\$647
				\$712	\$815

TN No: 13-0007-MM1 Hawaii

Approval Date: 09/13/2013 Attachment 2-1

Effective Date: 1/01/2014

50				1	Linna
				\$859	\$983
			5	\$1,006	\$1,151
			5	01,153	\$1,319
			7	\$1,300	\$1,487
			B	\$1,446	\$1,654
		2 Mil - 6	9	\$1,593	\$1,823
			10	\$1,740	\$1,991
			11	\$1,887	\$2,159
			12	\$2,034	\$2,327
			13	\$2,181	\$2,495
			14	\$2,328	\$2,663
			15	\$2,475	\$2,831
			addon	\$145	\$164
		and the second se	1	\$418	8469
	ben 6 months		2	\$565	\$634
	A second second		3	8712	\$799
			the second s	6859 .	6964
	1		4		81,129
			5	\$1,005	\$1,293
			6	\$1,153	
			7	\$1,300	\$1,458
			8	\$1,446	\$1,622
			9	\$1,593	\$1,787
			10	\$1,740	\$1,951
			11	\$1,887	\$2,116
			12	\$2,034	\$2,281
			13	\$2,181	\$2,445
			14	\$2,328	\$2,610
			15	\$2,475	\$2,775
	1		addon	\$146	\$161
Pregnant and children <1		1902(a) (10)(A)(1)(IV ) mandatory powerty level related pregnant women covered for pregnancy-related services and mandatory powerty- level related infan		185% FPL	1914 FFL
		1902 (a) (10) (A) (1) (VI			2 1
417 1-5		) mandatory poverty- level related children aged 1-5		1338 FPL	139% PPL
E. Chier, M		level related		100% FPL	1054 FPL
Child 1-5		level related children aged 1-5 1902(a)(10)(A)(1)(VJ I) mandatory poverty level related			
E. Chier, M		level related children aged 1-5 1902(a)(10)(A)(i)(V) I) mandatory poverty level related children aged 6-18		100% FPL	1054 FPL

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SUPERSEDING PAGES OF STATE PLAN MATERIAL					
TRANSMITTAL NUMBER:	STATE:				
13-0007-MM3	Hawaii				
PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:	PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable):				
S10 - MAGI Income Methodology	Notwithstanding any other, provisions of the Hawaii Medicaid State Plan, the financial eligibility methodologies described in State Plan Amendment HI-13-0007-MM3 will apply to all MAGI- based eligibility groups covered under Hawaii's Medicaid State Plan. The MAGI financial methodologies set forth in 42 CFR §435.603 apply to everyone except those individuals described at 42 CFR §435.603(j) for whom MAGI-based methods do not apply. This State Plan Amendment supersedes the current financial eligibility provisions of the Medicaid State Plan only with respect to the MAGI-based eligibility groups.				



State Name: Hawaii

Transmittal Number: 15 - - 0002

OMB Control Number: 0938-1148

Expiration date: 10/31/2014

**S10** 

### **MAGI-Based Income Methodologies**

1902(e)(14) 42 CFR 435.603

The state will apply Modified Adjusted Gross Income (MAGI)-based methodologies as described below, and consistent with 42 CFR 435.603.

In the case of determining ongoing eligibility for beneficiaries determined eligible for Medicaid on or before December 31, 2013, MAGI-based income methodologies will not be applied until March 31, 2014, or the next regularly-scheduled renewal of eligibility, whichever is later, if application of such methods results in a determination of ineligibility prior to such date.

In determining family size for the eligibility determination of a pregnant woman, she is counted as herself plus each of the children she is expected to deliver.

In determining family size for the eligibility determination of the other individuals in a household that includes a pregnant woman:

• The pregnant woman is counted just as herself.

C The pregnant woman is counted as herself, plus one.

C The pregnant woman is counted as herself, plus the number of children she is expected to deliver.

Financial eligibility is determined consistent with the following provisions:

When determining eligibility for new applicants, financial eligibility is based on current monthly income and family size.

When determining eligibility for current beneficiaries, financial eligibility is based on:

• Current monthly household income and family size

C Projected annual household income and family size for the remaining months of the current calendar year

In determining current monthly or projected annual household income, the state will use reasonable methods to:

Include a prorated portion of a reasonably predictable increase in future income and/or family size.

Account for a reasonably predictable decrease in future income and/or family size.

Except as provided at 42 CFR 435.603(d)(2) through (d)(4), household income is the sum of the MAGI-based income of every individual included in the individual's household.

In determining eligibility for Medicaid, an amount equivalent to 5 percentage points of the FPL for the applicable family size will be deducted from household income in accordance with 42 CFR 435.603(d).

Household income includes actually available cash support, exceeding nominal amounts, provided by the person claiming an individual described at  $\frac{435.603(f)(2)(i)}{435.603(f)(2)(i)}$  as a tax dependent.

(Yes (No

Page 1 of 2



The age used for children with respect to 42 CFR 435.603(f)(3)(iv) is:

• Age 19

C Age 19, or in the case of full-time students, age 21

### PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20140415



State Name: Hawaii

Transmittal Number: 16 - - 0001

### General Eligibility Requirements Eligibility Process

42 CFR 435, Subpart J and Subpart M

### **Eligibility Process**

The state meets all the requirements of 42 CFR 435, Subpart J for processing applications, determining and verifying eligibility, and furnishing Medicaid.

### **Application Processing**

Indicate which application the agency uses for individuals applying for coverage who may be eligible based on the applicable modified adjusted gross income standard.

The single, streamlined application for all insurance affordability programs, developed by the Secretary in accordance with section 1413(b)(1)(A) of the Affordable Care Act

An alternative single, streamlined application developed by the state in accordance with section 1413(b)(1)(B) of the Affordable Care Act and approved by the Secretary, which may be no more burdensome than the streamlined application developed by the Secretary.

### An attachment is submitted.

An alternative application used to apply for multiple human service programs approved by the Secretary, provided that the agency makes readily available the single or alternative application used only for insurance affordability programs to individuals seeking assistance only through such programs.

### An attachment is submitted.

Indicate which application the agency uses for individuals applying for coverage who may be eligible on a basis other than the applicable modified adjusted gross income standard:

The single, streamlined application developed by the Secretary or one of the alternate forms developed by the state and approved by the Secretary, and supplemental forms to collect additional information needed to determine eligibility on such other basis, submitted to the Secretary.

### An attachment is submitted.

An application designed specifically to determine eligibility on a basis other than the applicable MAGI standard which minimizes the burden on applicants, submitted to the Secretary.

### An attachment is submitted.

The agency's procedures permit an individual, or authorized person acting on behalf of the individual, to submit an application via the internet website described in 42 CFR 435.1200(f), by telephone, via mail, and in person.

The agency also accepts applications by other electronic means:

• Yes () No

OMB Control Number: 0938-1148

Expiration date: 10/31/2014

**S94** 



Indicate the other electronic means below:

	Name of Method	Description	
+	Facsimile	The agency accepts applications received via facsimile.	X
+	E-mail	The agency accepts applications received via e-mail.	X

The agency has procedures to take applications, assist applicants and perform initial processing of applications for the eligibility groups listed below at locations other than those used for the receipt and processing of applications for the title IV-A program, including Federally-qualified health centers and disproportionate share hospitals.

Parents and Other Caretaker Relatives

Pregnant Women

Infants and Children under Age 19

### **Redetermination Processing**

Redeterminations of eligibility for individuals whose financial eligibility is based on the applicable modified adjusted gross income standard are performed as follows, consistent with 42 CFR 435.916:

Once every 12 months

Without requiring information from the individual if able to do so based on reliable information contained in the individual's account or other more current information available to the agency

If the agency cannot determine eligibility solely on the basis of the information available to it, or otherwise needs additional information to complete the redetermination, it provides the individual with a pre-populated renewal form containing the information already available.

Redeterminations of eligibility for individuals whose financial eligibility is not based on the applicable modified adjusted gross income standard are performed, consistent with 42 CFR 435.916 (check all that apply):

- Once every 12 months
- Once every 6 months

Other, more often than once every 12 months

### **Coordination of Eligibility and Enrollment**

The state meets all the requirements of 42 CFR 435, Subpart M relative to coordination of eligibility and enrollment between Medicaid, CHIP, Exchanges and other insurance affordability programs. The single state agency has entered into agreements with the Exchange and with other agencies administering insurance affordability programs.



### PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20140415
#### Tell us about yourself.

1. First Name *	Middle			
	windule	Name	Last Name *	Suffix
				-
2. Home address (If state and zip code)	-	ease enter that you are h	nomeless with appropriate city,	
Address Line 1 *			3. Apartment or suite number	
4. City *	5. State * 6	Zin code *	7. Orwette	
+. Oity			7. County	
Please provide a ma	ailing address if differe	nt from your home addre	SS.	
3. Mailing Address	(leave blank if you don	't have one)		
Address Line 1			9. Apartment or suite number	
10. City	11. State 1	2. Zip code	13. County	
	•			
14. Phone number			15. Other phone number	
19. How many famil 20. Is any family me	erred Spoken Language ly members live with y ember you usually live	ou? with incarcerated	18. Preferred Written Languag Enter The Other Preferred Wri	
Enter The Other Prefe 19. How many famil 20. Is any family me	erred Spoken Language	ou? with incarcerated	Enter The Other Preferred Wri	
Enter The Other Prefe 19. How many famil 20. Is any family me (detained or jailed) o	erred Spoken Language ly members live with y ember you usually live	ou? with incarcerated	Enter The Other Preferred Wri	
Enter The Other Prefe 19. How many famil 20. Is any family me	erred Spoken Language ly members live with y ember you usually live or residing in the Hawa	ou? with incarcerated aii State Hospital?*	Enter The Other Preferred Wri	
Enter The Other Prefe 19. How many famil 20. Is any family me (detained or jailed) o	erred Spoken Language	ou? with incarcerated aii State Hospital? * Middle Name Release Date	Enter The Other Preferred Wri	
Enter The Other Prefe 19. How many famil 20. Is any family me (detained or jailed) o	erred Spoken Language ly members live with y ember you usually live or residing in the Hawa First Name *	ou? with incarcerated aii State Hospital? * Middle Name	Enter The Other Preferred Wri	tten Langua

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## PERSON 1 (Start with yourself)

Complete this step for yourself, your spouse/partner and children who live with you and/or anyone on your federal income tax return if you file one. If you do not file a tax return, remember to still add family members who live with you.

1. First Name *	Middle Name	Last Name	Suffix
2. Relationship to you ?	2* 3. Date of birth (mm/d	id/yyyy)* 4. Gender*	
5. Name of spouse if m	narried		
6. Social Security numb	per (SSN)		
7. Do you plan to file a YEAR? *	a federal income tax return NEX	T	
a. Will you jointly f	ile with a spouse? *	•	
Spouse *	First Name *	Middle Name	Last Name
b. Will you claim a	ny dependents on your tax retu	rn? *	
Name of dependent *	First Name *	Middle Name	Last Name
			Remove
			Remove
Name of dependent *	First Name *	Middle Name	Last Name *
	First Name *	Middle Name	
dependent *	First Name *		Last Name *
dependent* c. Will you be cla			Last Name *
dependent * c. Will you be cla return? * Name of Tax Filer *	imed as a dependent on someo	one's tax	Last Name * Add Dependent Last Name *
dependent * c. Will you be cla return? * Name of Tax Filer * Check here if th	imed as a dependent on someo	one's tax	Last Name * Add Dependent Last Name *
dependent * c. Will you be cla return? * Name of Tax Filer * Check here if th	imed as a dependent on someo First Name *	one's tax	Last Name * Add Dependent Last Name * sehold

## 9. Do you need health coverage?*

10. Do you have a disability that will last more than twelve (12) months?*	
a. Do you currently receive long term care nursing services?	•
b. Have you received long term care nursing services in the last three (3) months?	
From *	
То	
c. Do you think you need long term care nursing services now?	
d. Do you receive Supplemental Security Income (SSI)?	
11. Did you receive any medical services in the past ten (10) calendar days immediately prior to the date of application?	
a. If yes, what date(s)?	
From *	
То *	
12. Are you a U.S. citizen or U.S. national? *	
13. If you aren't a U.S. citizen or U.S. national, do you have	
eligible immigration status? *	
Immigration Document type *	
Immigration Document type *	
Immigration Document type *	
Immigration Document type * Status Type Write your name as it appears on your immigration document	
Immigration Document type * Status Type Write your name as it appears on your immigration document Alien Number 1	
Immigration Document type * Status Type Write your name as it appears on your immigration document Alien Number 1 I-94 Number 1 I-551/I-766 Card Number	
Immigration Document type * Status Type Write your name as it appears on your immigration document Alien Number 1 I-94 Number 1	
Immigration Document type * Status Type Write your name as it appears on your immigration document Alien Number 1 I-94 Number 1 I-551/I-766 Card Number	
Immigration Document type * Status Type Write your name as it appears on your immigration document Alien Number 1-94 Number 1-551/I-766 Card Number Passport Number	
Immigration Document type * Status Type Write your name as it appears on your immigration document Alien Number I-94 Number I-551/I-766 Card Number Passport Number SEVIS ID Number	
Immigration Document type * Status Type Write your name as it appears on your immigration document Alien Number 1-94 Number 1-951/I-766 Card Number Passport Number SEVIS ID Number Doc/Passport Expiration Date	

Other Document #		
Visa Number		
Document Description		
Citizenship Certificate Number		
Naturalization Certificate Numbe	r	
14. Provide the date of entry to the immigration document listed in Que		
a. Are you a citizen of the Fede Palau? *	rated States of Micronesia, Republ	ic of the Marshall Islands, or Republic of
● Yes ○ No		
Select Country of Citizenship *		
b. Are you, or your spouse or pa member of the US military?	rrent a veteran or an active duty	
15. Were you in foster care at age 1	18 or older in Hawaii?	
16. Are you a full time student?		
17. If Hispanic/Latino, ethnicity (OP	TIONAL - check all that apply.)	
Chicano/a	Cuban	Mexican
Mexican American	Puerto Rican	
Other		
18. Race (OPTIONAL-check all that	apply.)	
American Indian or Alaskan Native	Asian Indian	Black or African American
Chinese	Filipino	Guamanian or Chamorro
Japanese	Korean	Native Hawaiian
Other Asian	Other Pacific Islander	Samoan
Vietnamese	White	
Other		

### Current Job & Income Information

Type of Employment *

C Employed C Not Employed		
Employer name *		Phone number
Address Line 1 *		Apartment or suite number
City *	State *	Zip code *
Wages/tips (before taxes) *	How Often ? *	
	•	
	Income Start Date	Income End Date
		Remove
<b>5</b> *		
Employer name *		Phone number
Address Line 1 *		Apartment or suite number
City *	State *	Zip code *
	•	
Wages/tips (before taxes) *	How Often ?*	
	•	
	Income Start Date	Income End Date
Add new Jobs In the past year, did you:		
Self Employed		
f self-employed, answer the fo juestions	llowing	
	How much net income(profi	its once business expenses are paid) will you get pa
ype of work *	from this self-employment t	his month?*
THER INCOME THIS MONTH		
ncome Type	Amount(\$)	How Often ?
•		<b>v</b>
	Income Start Date	Income End Date
		Remove
Lesson Trees	A	
Income Type	Amount(\$)	How Often ?
	•	<b>_</b>
	Income Start Date	Income End Date

Add more income type

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#### DEDUCTIONS

Type of deduction	Amount(\$) Deduction Start Date	How Often ?
Type of deduction	Amount(\$) Deduction Start Date	Remove How Often ?  Deduction End Date
Add more deductions YEARLY INCOME Total income This year (\$)	Total income n	ext year(if different) (\$)
	Sa	ave & Exit Back Next

#### Person 2

Complete this step for yourself, your spouse/partner and children who live with you and/or anyone on your federal income tax return if you file one. If you do not file a tax return, remember to still add family members who live with you.

1. First Name *	Middle Name	e	Last Name *	Suffix
				•
2. Relationship to you	* 3. Date of bir	th (mm/dd/yyyy) *	4. Gender*	
5. Name of spouse if n	narried			
6. Social Security num	ber (SSN)			
7. Does PERSON 2 liv you?	e at the same address as			
Home Address (Leave	e blank if PERSON 2 do not I	nave one)		
Address Line 1 *			Apartment or suite	number
City *	State * Zip code	*	County	
	•			•
Please provide a mail	ing address if different from y	our home address.		
Mailing Address (leav	e blank if PERSON 2 doesn't	have one)		
Address Line 1			Apartment or suite	number
City	State Zip code	•	County	
	•			•
8. Does PERSON 2 pl: YEAR? *	an to file a federal income tax r	eturn NEXT	T	
a. Will PERSON 2 f	ile jointly with a spouse? *		•	
Name of	First Name *	Middle Name		.ast Name *
Spouse *				
b. Will PERSON 2 (	claim any dependents on their t	tax return? *	•	
Name of	First Name *	Middle Name		ast Name *
dependent *				
				Remove
Name of	First Name *	Middle Name	e La	ast Name *
dependent*				
				Add Dependent
c. Will PERSON 2 t someone's tax retu	e claimed as a dependent on rn? *			
Name of	First Name *	Middle Name	L	ast Name *
Tax Filer *				
Check here if the	person claiming PERSON 2 a	s a dependent is not	t part of the household	1
9. Is PERSON 2 pregr	nant? *			
•				
How many babies are	expected during this pregnand	cy? *	Expected Due Date *	
			L =	_

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#### 10. Does PERSON 2 need health coverage?*

11. Does PERSON 2 have a disability that will last more than twelve (12) months? *	•	
a. Does PERSON 2 currently receive long term care services?		•
b. Has PERSON 2 received long term care nursing services in the last three (3) months?		
From *		
То		
c. Does PERSON 2 think they need long term care nursing services now?		
d. Does PERSON 2 receive Supplemental Security Income (SSI)?	•	
12. Did PERSON 2 receive any medical services in the past ten (10) calendar days immediately prior to the date of application?	×	
a. If yes, what date(s)?		
From *		
То *		
13. Is PERSON 2 a U.S. citizen or U.S. national?*		
14. If PERSON 2 is not a U.S. citizen or U.S. national, does PERSON		
2 have eligible immigration status?*	•	
	•	
2 have eligible immigration status?*		
2 have eligible immigration status?*		×
2 have eligible immigration status? * Immigration Document type *		
2 have eligible immigration status? * Immigration Document type * Status Type		×
2 have eligible immigration status? * Immigration Document type * Status Type Write your name as it appears on your immigration document		
2 have eligible immigration status? * Immigration Document type * Status Type Write your name as it appears on your immigration document Alien Number ①		×
2 have eligible immigration status? * Immigration Document type * Status Type Write your name as it appears on your immigration document Alien Number 1 I-94 Number 1		
2 have eligible immigration status? * Immigration Document type * Status Type Write your name as it appears on your immigration document Alien Number 1 I-94 Number 1 I-551/I-766 Card Number		
2 have eligible immigration status? * Immigration Document type * Status Type Write your name as it appears on your immigration document Alien Number  I-94 Number I-551/I-766 Card Number Passport Number		
2 have eligible immigration status? * Immigration Document type * Status Type Write your name as it appears on your immigration document Alien Number I-94 Number I-951/I-766 Card Number Passport Number SEVIS ID Number		
2 have eligible immigration status? * Immigration Document type * Status Type Write your name as it appears on your immigration document Alien Number I-94 Number I-95 1/1-766 Card Number Passport Number SEVIS ID Number Doc/Passport Expiration Date		

Other Document #		
Visa Number		
Document Description		
Citizenship Certificate Numb	er	
Naturalization Certificate Nur	nber	
15. Provide the date of entry to th immigration document listed in (		
a. Is PERSON 2 a citizen of	the Federated States of Micronesia, Republ	ic of the Marshall Islands, or Republic of Palau'
C Yes C No		
Select Country of Citizenship	*	
b. Is PERSON 2 or their spou	use or parent, a veteran or an active duty	
member of the U.S. military?		
member of the U.S. military?	e at age 18 or older in Hawaii?	
member of the U.S. military? 16. Was PERSON 2 in foster car 17. Is PERSON 2 a full-time stud	e at age 18 or older in Hawaii?	
member of the U.S. military? 16. Was PERSON 2 in foster car 17. Is PERSON 2 a full-time stud	e at age 18 or older in Hawaii? Jent?	
member of the U.S. military? 16. Was PERSON 2 in foster car 17. Is PERSON 2 a full-time stud 18. If Hispanic/Latino, ethnicity	e at age 18 or older in Hawaii? tent? r (OPTIONAL - check all that apply.)	
member of the U.S. military? 16. Was PERSON 2 in foster car 17. Is PERSON 2 a full-time stud 18. If Hispanic/Latino, ethnicity	e at age 18 or older in Hawaii? dent? / (OPTIONAL - check all that apply.) Cuban	
member of the U.S. military? 16. Was PERSON 2 in foster car 17. Is PERSON 2 a full-time stud 18. If Hispanic/Latino, ethnicity Chicano/a Mexican American	e at age 18 or older in Hawaii? tent? v (OPTIONAL - check all that apply.) Cuban Puerto Rican	
member of the U.S. military? 16. Was PERSON 2 in foster car 17. Is PERSON 2 a full-time stud 18. If Hispanic/Latino, ethnicity Chicano/a Mexican American Other 19. Race (OPTIONAL-check al American Indian or Alaskan	e at age 18 or older in Hawaii? tent? r (OPTIONAL - check all that apply.) Cuban Puerto Rican	Mexican
member of the U.S. military? 16. Was PERSON 2 in foster car 17. Is PERSON 2 a full-time stud 18. If Hispanic/Latino, ethnicity Chicano/a Mexican American Other 19. Race (OPTIONAL-check al American Indian or Alaskan Native	e at age 18 or older in Hawaii? dent? r (OPTIONAL - check all that apply.) Cuban Puerto Rican	Mexican
member of the U.S. military? 16. Was PERSON 2 in foster car 17. Is PERSON 2 a full-time stud 18. If Hispanic/Latino, ethnicity Chicano/a Mexican American Other 19. Race (OPTIONAL-check al American Indian or Alaskan Native Chinese	e at age 18 or older in Hawaii? tent? r (OPTIONAL - check all that apply.) Cuban Puerto Rican	Mexican Black or African American Guamanian or Chamorro
member of the U.S. military? 16. Was PERSON 2 in foster car 17. Is PERSON 2 a full-time stud 18. If Hispanic/Latino, ethnicity Chicano/a Mexican American Other 19. Race (OPTIONAL-check al American Indian or Alaskan Native	e at age 18 or older in Hawaii? dent? r (OPTIONAL - check all that apply.) Cuban Puerto Rican	Mexican
member of the U.S. military? 16. Was PERSON 2 in foster car 17. Is PERSON 2 a full-time stud 18. If Hispanic/Latino, ethnicity Chicano/a Mexican American Other 19. Race (OPTIONAL-check al American Indian or Alaskan Native Chinese Japanese	e at age 18 or older in Hawaii? dent? (OPTIONAL - check all that apply.) Cuban Puerto Rican Il that apply.) Asian Indian Filipino Korean	Mexican Black or African American Guamanian or Chamorro Native Hawaiian

#### Current Job & Income Information

	Not Employed	
Employer name *		Phone number
Address Line 1 *		Apartment or suite number
City *	State *	Zip code *
Nages/tips (before taxes) *	How Often ?*	
	Income Start Date	Income End Date
		Remove
		an and a second s
Employer name [*]		Phone number
Address Line 1*		Anastmant er suite number
hudiess Line 1		Apartment or suite number
*		
City *	State *	Zip code *
2		
Wages/tips (before taxes) *	How Often ?*	
	Income Start Date	Income End Date
Add new Jobs		
Add new Jobs the past year, did PERSON 2:		
the past year, did PERSON 2:	llowing	
the past year, did PERSON 2:	llowing	
the past year, did PERSON 2: Self Employed self-employed, answer the for uestions	How much net income(profi	
the past year, did PERSON 2:		
the past year, did PERSON 2: Self Employed self-employed, answer the for uestions	How much net income(profi	
the past year, did PERSON 2: Self Employed self-employed, answer the for uestions	How much net income(profi	
the past year, did PERSON 2: Self Employed self-employed, answer the for uestions pe of work *	How much net income(profi	its once business expenses are paid) will you his month? * How Often ?
the past year, did PERSON 2: Self Employed self-employed, answer the for Jestions pe of work * THER INCOME THIS MONTH	How much net income(profi from this self-employment t Amount(\$)	his month? *
the past year, did PERSON 2: Self Employed self-employed, answer the for sestions pe of work * THER INCOME THIS MONTH come Type	How much net income(profi from this self-employment t Amount(\$)	his month? *
the past year, did PERSON 2: Self Employed self-employed, answer the for sestions pe of work * THER INCOME THIS MONTH come Type	How much net income(profi from this self-employment t Amount(\$)	his month? * How Often ?
the past year, did PERSON 2: Self Employed self-employed, answer the for sestions pe of work * THER INCOME THIS MONTH come Type	How much net income(profi from this self-employment t Amount(\$)	his month? * How Often ? Income End Date
the past year, did PERSON 2: Self Employed self-employed, answer the for sestions pe of work * THER INCOME THIS MONTH come Type	How much net income(profi from this self-employment t Amount(\$)	How Often ?
the past year, did PERSON 2: Self Employed self-employed, answer the for sestions pe of work * THER INCOME THIS MONTH come Type	How much net income(profi from this self-employment t Amount(\$) Income Start Date	his month? * How Often ? Income End Date Remove How Often ?
the past year, did PERSON 2: Self Employed self-employed, answer the for sestions pe of work * THER INCOME THIS MONTH come Type	How much net income(profi from this self-employment t Amount(\$) Income Start Date	his month? *

#### DEDUCTIONS

Type of deduction	Amount(\$)	How Often	?
•			-
	Deduction Start Date	Deduction	End Date
			Remove
Type of deduction	Amount(\$)	How Often ?	
			-
	Deduction Start Date	Deduction E	nd Date
Add more deductions			
YEARLY INCOME			
	PERSON 2	's total income next ye	ar (if you think it will be
PERSON 2's total income this year? (\$)	different)?		
		Remove	Person Add Person
		Save & Exit	Back Next

### Person 3

Complete this step for yourself, your spouse/partner and children who live with you and/or anyone on your federal income tax return if you file one. If you do not file a tax return, remember to still add family members who live with you.

1. First Name *	Middle Nam	e	Last Name *	Suffix
2. Relationship to y	ou * 3. Date of bi	rth (mm/dd/yyyy) *	4. Gender *	
	<b>•</b>		-	
5. Name of spouse	if married			
6. Social Security nu	umber (SSN)			
7. Does PERSON 3 you?	live at the same address as		No	
Home Address (Le	eave blank if PERSON 3 do not	have one)		
Address Line 1 *			Apartment or suit	te number
City *	State * Zip code	*		
			County	
				•
Please provide a n	nailing address if different from y	our home address.		
Mailing Address (I	eave blank if PERSON 3 doesn'	t have one)		
Address Line 1		,	Apartment or suit	ie number
			Apartment of Sul	
City	State Zip code	e	County	
				-
	plan to file a federal income tax r	eturn NEXT	•	
YEAR? *				
a. Will PERSON	3 file jointly with a spouse? *			
	First Marco *			Lasthic *
Name of	First Name *	Middle Name		Last Name *
Spouse *				
b. Will PERSON	3 claim any dependents on their	tax return? *		
	First Marris *			Leathers *
Name of	First Name *	Middle Name	•	Last Name *
dependent *				
				Add Depende
c. Will PERSON someone's tax r	3 be claimed as a dependent on return? *		•	
Name of	First Name *	Middle Name		Last Name *
Tax Filer *				
Check here if f	the person claiming PERSON 3 a	s a dependent is no	t part of the househ	old
	ON 3 related to the tax filer?			
				•
9. Is PERSON 3 pre	anant2 *			
	synallt:			
-				
How many babies a	are expected during this pregnand	cy? *	Expected Due Date	· •
<b>•</b>		• • -		
16-0001 edes TN No: 14-0	1008	Approval D Online Applica	ate: 04/03/2017	
uco IN INU. 14-0			uuu - 12	

10.	Does	PERSON	3	need	health	coverage? *	
-----	------	--------	---	------	--------	-------------	--

11. Does PERSON 3 have a disability that will last more than twelve (12) months? *	
a. Does PERSON 3 currently receive long term care services?	•
b. Has PERSON 3 received long term care nursing services in the last three (3) months?	
From *	
То	
c. Does PERSON 3 think they need long term care nursing services now?	
d. Does PERSON 3 receive Supplemental Security Income (SSI)?	
12. Did PERSON 3 receive any medical services in the past ten (10) calendar days immediately prior to the date of application?	
a. If yes, what date(s)?	
From *	
То *	
13. Is PERSON 3 a U.S. citizen or U.S. national? *	
14. If PERSON 3 is not a U.S. citizen or U.S. national, does PERSON	
3 have eligible immigration status? *	
3 have eligible immigration status? * Immigration Document type *	
	•
Immigration Document type *	
Immigration Document type *	
Immigration Document type * Status Type Write your name as it appears on your immigration document	
Immigration Document type * Status Type Write your name as it appears on your immigration document Alien Number ①	
Immigration Document type * Status Type Write your name as it appears on your immigration document Alien Number 1 I-94 Number 1	
Immigration Document type * Status Type Write your name as it appears on your immigration document Alien Number 1 I-94 Number 1 I-551/I-766 Card Number	
Immigration Document type * Status Type Write your name as it appears on your immigration document Alien Number 1 I-94 Number 1 I-551/I-766 Card Number Passport Number	
Immigration Document type * Status Type Write your name as it appears on your immigration document Alien Number I-94 Number I-551/I-766 Card Number Passport Number SEVIS ID Number	
Immigration Document type *  Status Type Write your name as it appears on your immigration document Alien Number I-94 Number I-951/I-766 Card Number Passport Number SEVIS ID Number Doc/Passport Expiration Date	

Other Document #				
Visa Number				
Document Description				
Citizenship Certificate Number				
Naturalization Certificate Number				
15. Provide the date of entry to the U.S. immigration document listed in Questi				
a. Is PERSON 3 a citizen of the Fea *	derated States of Micronesia, Republ	ic of the Marshall Islands, or Republic of Palau?		
⊖ Yes ⊖ No				
Select Country of Citizenship *				
b. Is PERSON 3 or their spouse or member of the U.S. military?	parent, a veteran or an active duty			
16. Was PERSON 3 in foster care at ag	e 18 or older in Hawaii?			
18. If Hispanic/Latino, ethnicity (OPT	IONAL - check all that apply.)			
Chicano/a	Cuban	Mexican		
Mexican American	Puerto Rican			
Other				
19. Race (OPTIONAL-check all that	apply.)			
American Indian or Alaskan Native	Asian Indian	Black or African American		
Chinese	Filipino	Guamanian or Chamorro		
Japanese	Korean	Native Hawaiian		
Other Asian	Other Pacific Islander	Samoan		
Vietnamese	White			
Other				

#### Current Job & Income Information

.

C Employed	O Not Employed	
Employer name *		Phone number
Address Line 1 *		Apartment or suite number
City *	State *	Zip code *
Wages/tips (before taxes) *	How Often ? *	
	Income Start Date	Income End Date
		Remove
Employer name *		Phone number
Address Line 1 *		Apartment or suite number
City *	State *	Zip code *
	HI	
Wages/tips (before taxes) *	How Often ?*	
	Income Start Date	Income End Date
Add new Jobs		
n the past year, did PERSON 3:		
Self Employed		
f self-employed, answer the fo uestions	ollowing	
ype of work *	How much net income(prof from this self-employment	fits once business expenses are paid) will you get pa this month? *
THER INCOME THIS MONTH		
ncome Type	Amount(\$)	How Often ?
		•
	Income Start Date	Income End Date
		Remove
Income Type	Amount(\$)	How Often ?
	Income Start Date	Income End Date

#### DEDUCTIONS

Type of deduction	Amount(\$) Deduction Start Date		Often ? ction End Date	Y
Type of deduction	Amount(\$) Deduction Start Date	How Of Deduct		emove
Add more deductions YEARLY INCOME				
PERSON 3's total income this year? (\$)	PERSON 3 different)?	(\$)	next year (if you th	
		Ren Save & Exit	nove Person Back	Add Person Next

### Person 4

Complete this step for yourself, your spouse/partner and children who live with you and/or anyone on your federal income tax return if you file one. If you do not file a tax return, remember to still add family members who live with you.

1. First Name *	Middle Name		Last Name *		Suffix
					•
2. Relationship to you *	3. Date of birth (n	nm/dd/yyyy) *	4. Gender *		
			•		
5. Name of spouse if marri	ed				
6. Social Security number (	(SSN)				
7. Does PERSON 4 live at 1 you?	the same address as		•		
Home Address (Leave bla	ank if PERSON 4 do not have	one)			
Address Line 1 *			Apartment or sui	te number	
City*	State * Zip code *				
			County		
				•	
Please provide a mailing a	address if different from your	home address.			
Mailing Address (lague bl	ank if DEDSON 4 decen't he	(0.000)			
Address Line 1	ank if PERSON 4 doesn't hav	e one)	Apartment or sui	to purphor	
Address Line T			Apartment or su	te number	
	<b>-</b>				
City	State Zip code		County		
	•			•	
	file a federal income tax return	NEXT	•		
YEAR?*					
a. Will PERSON 4 file jo	intly with a spouse? *		•		
Name of Firs	t Name *	Middle Name		Last Name *	
Spouse *					
b. Will PERSON 4 claim	any dependents on their tax re	eturn? *	•		
<b>F</b> i-	st Name *			Last Name *	
Name of	stName	Middle Name		Lastiname	
dependent *					
					Remove
_					
Name of	First Name *	Middle Name		Last Name *	
dependent *					
				Add De	ependent
c. WIII PERSON 4 be cla someone's tax return?	aimed as a dependent on *		•		
Name of	t Name *	Middle Name		Last Name *	
Tax Filer *					
Check here if the pers	on claiming PERSON 4 as a d	ependent is not	part of the househ	old	
How is PERSON 4 rel		Γ		-	
16-0001		Approval Date	e: 04/03/2017		Efective Date: 9/

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10.	Does	PERSON 4	need health	coverage? *
-----	------	----------	-------------	-------------

#### ○ Yes ○ No

11. Does PERSON 4 have a disability that will last more than twelve (12) months? *		
a. Does PERSON 4 currently receive long term care services?		•
b. Has PERSON 4 received long term care nursing services in the last three (3) months?		
From *		
То		
c. Does PERSON 4 think they need long term care nursing services now?		
d. Does PERSON 4 receive Supplemental Security Income (SSI)?		
12. Did PERSON 4 receive any medical services in the past ten (10) calendar days immediately prior to the date of application?		
a. If yes, what date(s)?		
From *		
То*		
13. Is PERSON 4 a U.S. citizen or U.S. national? *		
14. If PERSON 4 is not a U.S. citizen or U.S. national, does PERSON		
4 have eligible immigration status? *		
4 have eligible immigration status? * Immigration Document type *		
	V	
Immigration Document type *		
Immigration Document type *		
Immigration Document type * Status Type Write your name as it appears on your immigration document		
Immigration Document type * Status Type Write your name as it appears on your immigration document Alien Number ①		
Immigration Document type * Status Type Write your name as it appears on your immigration document Alien Number 1 I-94 Number 1		
Immigration Document type * Status Type Write your name as it appears on your immigration document Alien Number  I-94 Number  I-951/I-766 Card Number		
Immigration Document type * Status Type Write your name as it appears on your immigration document Alien Number 1 I-94 Number 1 I-551/I-766 Card Number Passport Number		
Immigration Document type * Status Type Write your name as it appears on your immigration document Alien Number  I-94 Number I-551/I-766 Card Number Passport Number SEVIS ID Number		
Immigration Document type * Status Type Write your name as it appears on your immigration document Alien Number I-94 Number I-95 1/I-766 Card Number Passport Number SEVIS ID Number Doc/Passport Expiration Date		

Other Document #		
Visa Number		
Document Description		
Citizenship Certificate Number		
Naturalization Certificate Number		
15. Provide the date of entry to the U.S. immigration document listed in Quest		
a. Is PERSON 4 a citizen of the Fe *	derated States of Micronesia, Republ	ic of the Marshall Islands, or Republic of Palau?
O Yes O No		
Select Country of Citizenship *		•
b. Is PERSON 4 or their spouse or member of the U.S. military?	parent, a veteran or an active duty	
16. Was PERSON 4 in foster care at a 17. Is PERSON 4 a full-time student?	ge 18 or older in Hawaii?	
TT. IS PERSON 4 a full-time student?		•
18. If Hispanic/Latino, ethnicity (OP	TIONAL - check all that apply.)	
Chicano/a	Cuban	Mexican
Mexican American	Puerto Rican	
Other		
19. Race (OPTIONAL-check all that	apply.)	
American Indian or Alaskan Native	Asian Indian	Black or African American
Chinese	Filipino	Guamanian or Chamorro
Japanese	Korean	Native Hawaiian
Other Asian	Other Pacific Islander	Samoan
Vietnamese	White	
Other		

#### Current Job & Income Information

ype of Employment *		
C Employed	O Not Employed	
Employer name *		Phone number
Address Line 1 *		Apartment or suite number
City *	State *	Zip code *
Wages/tips (before taxes) *	How Often ? * Income Start Date	Income End Date
Employer name *		Remove Phone number
Address Line 1 *		Apartment or suite number
City *	State *	Zip code *
Wages/tips (before taxes) *	How Often ?*	
	Income Start Date	Income End Date

#### Add new Jobs

In the past year, did PERSON 4:

Type of work *

If self-employed,	answer	the	following
questions			

•

How much net income(profits	once business expenses	are paid) will you get paid
from this self-employment thi	s month? *	

#### OTHER INCOME THIS MONTH

Income Type	Amount(\$) Income Start Date	How Often ?
Income Type	Amount(\$) Income Start Date	Remove How Often ?  Income End Date

#### Add more income types TN No: 16-0001 Supercedes TN No: 14-0008

#### DEDUCTIONS

Type of deduction	Amount(\$) Deduction Start Date	How Often ?	
Type of deduction	Amount(\$) Deduction Start Date	Remove How Often ? Deduction End Date	
Add more deductions YEARLY INCOME PERSON 4's total income this year? (\$)	PERSON 4's different)? (\$	s total income next year (if you think it will be 6) Remove Person Add Pers	on
		Save & Exit Back Next	

First Name	Middle Name	Last Name	Gender	Date Of Birth	Define Relationships
					Self
					0
					0
					0

Listed below are child(ren) under 19 years old who belong to your household. Please check the box if you are primarily responsible for the care of these child(ren). *
None of them
Note: 'None of them' cannot be selected if other check box is checked.
Use the following relationships to identify relationships to household members.
Relationship to *
Listed below are child(ren) under 19 years old who belong to your household.
Please check the box if you are primarily responsible for the care of these child(ren). *
None of them
Note: 'None of them' cannot be selected if other check box is checked.
Use the following relationships to identify relationships to household members.
Relationship to *
Relationship to *
Relationship to *
Use the following relationships to identify relationships to household members.
Relationship to *
Relationship to *
Relationship to *
Sovo & Evit Back Novt

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#### **Tax Dependents**

Answer these questions for everyone applying for help paying for health insurance.

If you indicated tax relationships to other people, but do not see them on this page, please go back to Household Details to add them to this application.

Does	plan to file a federal income tax return	NEXT YEAR?*		0	/es 🔘 No
Will	file jointly with a spouse?				
		First	Middle	Last	Suffix
		Name	Name	Name	Gallix
Will	claim any dependents on their tax return	?		•	
		First	Middle	Last	Suffix
		Name	Name	Name	Callin
Will	be claimed as a dependent on someon	e's tax return?		•	
_		_			
		First Name	Middle Name	Last Name	Suffix
	Г				

Check here if the tax filer claiming as a dependent is not part of the household.



ne N nt is not part of th rEAR?*	Middle Name		Yes O Suffix
st N he N nt is not part of th rEAR? *	he househol	Last Name	Yes 🔘
st N he N nt is not part of th rEAR? *	he househol	Last Name	Yes 🔘
st N he N nt is not part of th rEAR? *	he househol	Last Name	Yes 🔘
ne N nt is not part of th rEAR?*	he househol	Name d. Last	Yes 🔘
rear?*	Middle	C Last	
st N		Last	
		Last	Suffix
			Suffix
		•	
	Middle Name	Last Name	Suffix
return?			
	Middle Name	Last Name	Suffix
nt is not part of ti	the househol	d.	



First Name	Middle Name	Last Name	Suffix

Will be claimed as a dependent on someone's tax return?

	First Name	Middle Name	Last Name	Suffix
Γ				
Check here if the tax filer claiming	as a dependent is not p	art of the household	<b>1</b> .	

How is related to the tax filer?

•

•

#### Incarcerated Family Member(s)

Answer these questions for everyone applying for help paying for health insurance.

If you indicated someone as incarcerated or residing in the Hawaii State Hospital, but do not see them on this page, please go back to Household Details to add them to this application.

Is any family member incarcerated (detained or jailed) or residing in the Hawaii State	0	Yes	~	No	
Hospital?*	0	165	0	NU	

Name of Family Member

First Name	Middle Name	Last Name	Suffix	Start Date	Release Date

		Save & Exit	Back	Next	
--	--	-------------	------	------	--

#### Your Family's Health Coverage

Is anyone listed on this application enrolled in health coverage now?*

No. If no, skip to next step. Next

Yes. If Yes, answer the following questions.

enrolled in health coverage now?* ls C Yes C No

Type of Coverage(s) *	Policy Name *	Policy Nur	nber	
Policy Start Date *	Policy End Date			
ncludes medical care?	○ Yes ○ No			
ncludes dental care?	C Yes C No			
ncludes vision care?	C Yes C No			
s this a limited-benefit plan, like a school accident policy?	C Yes C No			
Coverage Details				Add Coverage
ype of Coverage(s) *	Policy Name *	Policy Nur	nber	
Policy Start Date *	Policy End Date			
ncludes medical care?	C Yes C No			
ncludes dental care?	C Yes C No			
ncludes vision care?	C Yes C No			
s this a limited-benefit plan, like a school accident policy?	C Yes C No		100	
			Remove (	
Is enrolled in health coverag	e now?"		0	Yes C No
s enrolled in health coverag	e now? <mark>*</mark>		C	Yes ( No
s enrolled in health coverag	e now?*		C	Yes 🤇 No
		Save & Exit	Back	Next

#### Health Coverage from Jobs

Is anyone listed on this application offered health coverage from a job?*

No. If no, skip to next step.

No. If no, skip to next step.

Yes. If yes, answer the following questions.

Is this a state employee benefit plan?* O Yes O No

Employer name

Employer Identification Number (EIN)

Remove Employer

Add Employer

You DON'T need to answer these questions unless someone in the household is eligible for health coverage from a job.

Tell us about the job that offers coverage.

#### Select Employee *

	First Name	Middle Name	Last Name
C			
C			
C			
с			

1. Employer name *	
2. Employer Identification Number (EIN)	3. Employer phone number *
4. Address Line 1 *	5. Address Line 2
6. City* 7. State*	8. Zip code *
9. Who can we contact about employee health coverage at this job? st	
10. Phone Number *	11. Email Address
12. Are you currently eligible for coverage offered by this employer, or will you become eligible in the next 3 months? *	C Yes C No
12a. If you're in a waiting or probationary period, when can you enroll in coverage? $st$	
Who does this job offer coverage to? *	

	First Name	Middle Name	Last Name	
Г				
-				

Tell us about the health plan offered by this employer.

13. Does the employer offer a health plan that meets the minimum value standard? *  $\hfill C$  Yes  $\hfill C$  No

14. For the lowest-cost plan that meets the minimum value standard* offered only to the employee (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and did not receive any other discounts based on wellness programs.

14a. How much would the employee have to pay in premiums for this plan? \$ *
14b. How often? *
15. What change will the employer make for the new plan year (if known)?
Employer won't offer health coverage
Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.
a. How much would the employee have to pay in premiums for this plan? \$ *
b. How often? *
Date of change (mm/dd/yyyy) *

American Indian on A		
American Indian of A	askan Native Family Member (Al/AN)	
Are you or anyone in your	family American Indian or Alaskan Native?*	
No. No one in my family	is American Indian or Alaskan Native. Next	
Yes. If yes, answer the	ollowing questions.	
Is an American Indian or	laskan Native? *	⊂ Yes ⊂ No
Is a member of a Federally re	cognized Tribe ? *	
○ Yes ○ No		
lf yes, Tribe name is *		
Has ever gotten a service fro referral from one of these prog	m the Indian Health Service, a tribal health program, o rams. *	or urban Indian health program, or through a
C Yes C No		
Is eligible to get services from	n the Indian Health Service, tribal health programs, or	urban Indian health programs, or through a
referral from one of these prog	rams?*	
C Yes C No		
	ot be counted for Medicaid or the Children's Health Ins ed on your application that includes money from these	
Per capita payments fi	om a tribe that come from natural resources, usage ri	ights, leases, or royalties
	resources, farming, ranching, fishing, leases, or roya	
	t of Interior (including reservations and former reserva ngs that have cultural significance	alions)
- money norm sening un	iyo machave cultural olymillallite	
Amount (\$):	How often?	

5	an American Indian or Alaskan Native? *	C Yes C No
s	an American Indian or Alaskan Native? *	C Yes C No
s	an American Indian or Alaskan Native? *	C Yes C No

#### Authorized Representative

You can give a trusted person permission to talk about this application with us, see your information and act for you on matters related to this application, including getting information about your application and signing your application on your behalf. This person is called an "authorized representative".

If you ever need to change your authorized representative, call 1-800-316-8005.

#### Would you like to include an authorized representative?*

No. I would not like to provide an authorized representative.

Yes. If Yes, answer the following questions.

First Name *	Middle Name	Last Name *	Suffix
Address Line 1 *		Apartment or suite	number
City *	State * Zip Code *	County	T
Phone Number *			
Organization Name	ID Number (If applicable)		
		Save & Exit	Back Next

- I'm signing this application 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 federal law if I intentionally provide false and/or untrue information.
- I know that I must tell the Department of Human Services or the Federal Health Insurance Marketplace if anything changes (and is different than) what I wrote on this application. I can visit <u>mybenefits.hawaii.gov</u> or call 1-800-316-8005 (TTY: Oahu 808-692-7182 or NI 1-800-603-1201) or visit <u>www.Healthcare.gov</u> or call 1-800-318-2596 (TTY: 1-855-889-4325) to report any changes. I understand that a change in my information could affect the eligibility for members of my household.
- I know that under federal law, discrimination isn't permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, or disability. I can file a complaint of discrimination by visiting. www.hhs.gov/ocr/office/file

I understand the Department of Human Services or the Federal Health Insurance Marketplace will obtain information to verify eligibility with electronic databases, to include but not limited to, the Internal Revenue Service (IRS), Social Security Administration (SSA), Department of Homeland Security (DHS), or a consumer reporting agency. If the information doesn't match, we may ask you to send us proof.

#### Renewal of coverage in future years

To make it easier to determine my eligibility for help paying for health coverage in future years, I agree to allow the Federal Health Insurance Marketplace to use income data, including information from tax returns. The Federal Health Insurance Marketplace will send me a notice, let me make any changes, and I can opt out at any time.

•

#### Yes, renew my eligibility automatically for the next*

#### If Yes, I understand .... I may not have to cooperate.

- I am assigning the Department of Human Services, my rights to payments for medical care from any third party, which may include but not limited to, other health insurance or legal settlement. I am also assigning the Department of Human Services, my rights to pursue and get medical support from a spouse or parent. I will cooperate in obtaining third party payments.
- Does any child on this application have a parent living outside of the home?*
  - Yes No
- If Yes, I understand I will be asked to cooperate with the Department of Human Services and the agency that collects medical support from an absent parent. If I think that cooperating to collect medical support will harm me or my children, I can tell Medicaid and I may not have to cooperate.

#### My right to appeal

If I think the Department of Human Services or the Federal Health Insurance Marketplace has made a mistake, I can appeal its decision. To appeal means to tell someone at the Department of Human Services or the Federal Health Insurance Marketplace that I think the action is wrong, and 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 application.

The person who filled out Step 1 should sign this application. If you're an authorized representative you may sign here with your name, as long as you have provided the information required in Appendix C.

I agree to the Terms and	Primary Applicant First Name *	Primary Applicant Last Name *
Conditions *		

Approval Date: 04/03/2017 Online Application -32

Save & Exit

Efective Date: 9/1/2016

Federal Health Insurance Marketplace

# **Application For Health Coverage & Help Paying Costs**

	3	Use this application to see what coverage choices you qualify for	<ul> <li>Affordable private health insurance plans that offer comprehensive coverage to help you stay well.</li> <li>A new tax credit that can immediately help pay your premiums for health coverage.</li> <li>Free or low-cost insurance from Medicaid or the Children's Health Insurance Program (CHIP).</li> </ul>
	<b>&amp;</b>	Who can use this application?	<ul> <li>Use this application to apply for you or anyone in your family.</li> <li>Apply even if you or your child already have health coverage. You could be eligible for lower-cost or free coverage.</li> <li>Families that include immigrants can apply. You can apply for your child even if you are not eligible for coverage. Applying will not affect your immigration status or chances of becoming a permanent resident or citizen.</li> <li>If someone is helping you fill out this application, you may need to complete Appendix C.</li> </ul>
KNOW		Apply faster online	<ul> <li>Apply faster online at <u>mybenefits.hawaii.gov</u>.</li> <li>If you want to purchase insurance without help, apply directly at <u>www.healthcare.gov</u>.</li> </ul>
GS TO	B	What you may need to apply	<ul> <li>Social Security Numbers (or document numbers for any legal immigrants who need insurance).</li> <li>Employer and income information for everyone in your family (for example, from pay stubs, W-2 forms, or wage and tax statements).</li> <li>Policy numbers for any current health insurance.</li> <li>Information about any job-related health insurance available to your family.</li> </ul>
THIN	i	Why do we ask for this information?	We ask about income and other information to let you know what coverage you qualify for and if you can get any help paying for it. We will keep all the information you provide private and secure, as required by law. To view the Privacy Act Statement, go to mybenefits.hawaii.gov.
	6	What happens next?	Send your complete, signed application to the address on page 9. If you do not have all the information we ask for, sign and submit your application anyway. We will follow-up with you within 1-2 weeks. You will get instructions on the next steps to complete your health coverage. If you do not hear from us, visit <u>mybenefits.hawaii.gov</u> or call 1-877-628-5076 (TTY/TDD 1-855-585-8604). Filling out this application does not mean you have to buy health insurance.
	?	Get help with this application	<ul> <li>Online: <u>mybenefits.hawaii.gov</u></li> <li>Phone: Call the Contact Center at 1-877-628-5076 (TTY/TDD 1-855-585-8604) for assistance with completing and submitting an application or getting information on the status of your application.</li> <li>In person: There may be counselors in your area who can help. Visit our website or call 1-877-628-5076 (TTY/TDD 1-855-585-8604) for more information.</li> <li>Medicaid: For specific questions on Medicaid/CHIP eligibility, call 1-800-316-8005 (TTY/TDD 1-800-603-1201).</li> </ul>

NEED HELP WITH YOUR APPLICATION? Visit <u>mybenefits.hawaii.gov</u> or call us at 1-877-628-5076. If you need help in a language other than English, call 1-877-628-5076 and tell the customer service representative the language you need. We will get you help at no cost to you. TTY/TDD users should call 1-855-585-8604.

?

Do you need help in another language? We will get you a free interpreter. Call <b>1-877-628-5076</b> to tell us which language you speak. (TTY: 1-855-585-8604 or 711).	English
您需要其它語言嗎? 如有需要, 請致電 1-877-628-5076, 我們會提供免費翻譯服務 (TTY: 1-855-585-8604 或 711).	Cantonese
En mi niit alilis lon pwal eu kapas? Sipwe angei emon chon chiaku ngonuk ese kamo. Kokori <b>1-877-628-5076</b> omw kopwe ureni kich meni kapas ka ani. (TTY: 1-855-585-8604 ika 711).	Chuukese
Avez-vous besoin d'aide dans une autre langue? Nous pouvons vous fournir gratuitement des services d'un interprète. Appelez le <b>1-877-628-5076</b> pour nous indiquer quelle langue vous parlez. (TTY: 1-855-585-8604 ou 711).	French
Brauchen Sie Hilfe in einer andereren Sprache? Wir koennen Ihnen gern einen kostenlosen Dolmetscher besorgen. Bitte rufen Sie uns an unter <b>1-877-628-5076</b> und sagen Sie uns Bescheid, welche Sprache Sie sprechen. (TTY: 1-855-585-8604 oder 711).	German
Makemake `oe i kokua i pili kekahi `olelo o na `aina `e? Makemake la maua i ki`i `oe mea unuhi manuahi. E kelepona <b>1-877-628-5076</b> `oe ia la kaua a e ha`ina `oe ia la maua mea `olelo o na `aina `e. (TTY: 1-855-585-8604 a 711).	Hawaiian
Masapulyo kadi ti tulong iti sabali a pagsasao? Ikkandakayo iti libre nga paraipatarus. Awaganyo ti <b>1-877-628-5076</b> tapno ibagayo kadakami no ania ti pagsasao nga ar-aramatenyo. (TTY: 1-855-585-8604 wenno 711).	Ilokano
貴方は、他の言語に、助けを必要としていますか? 私たちは、貴方のために、無料で通訳を用意できます。電話番号の、1-877-628-5076に、電話して、私たちに貴方の話されている言語を申し出てください。(TTY: 1-855-585-8604 または 711).	Japanese
다른언어로 도움이 필요하십니까? 저희가 무료로 통역을 제공합니다. 1-877-628-5076 로 전화해서 사용하는 언어를 알려주십시요 (TTY: 1-855-585-8604 1 또는 711).	Korean
您需要其它语言吗?如有需要,请致电 1-877-628-5076,我们会提供免费翻译服务 (TTY: 1-855-585-8604 或 711).	Mandarin *3
Kwoj aikuij ke jiban kin juon bar kajin? Kim naj lewaj juon am dri ukok eo ejjelok wonen. Kirtok <b>1-877-628-5076</b> im kwalok non kim kajin ta eo kwo melele im kenono kake. (TTY: 1-855-585-8604 ak 711).	Marshallese
E te mana'o mia se fesosoani i se isi gagana? Matou te fesosoani e ave atu fua se faaliliu upu mo oe. Vili mai i le numera lea <b>1-877-628-5076</b> pea e mana'o mia se fesosoani mo se faaliliu upu. (TTY: 1-855-585-8604 po o le 711).	Samoan
¿Necesita ayuda en otro idioma? Nosotros le ayudaremos a conseguir un intérprete gratuito. Llame al <b>1-877-628-5076</b> y diganos que idioma habla. (TTY: 1-855-585-8604 o 711).	Spanish
Kailangan ba ninyo ng tulong sa ibang lengguwahe? Ikukuha namin kayo ng libreng tagasalin. Tumawag sa <b>1-877-628-5076</b> para sabihin kung anong lengguwahe ang nais ninyong gamitin. (TTY: 1-855-585-8604 o 711).	Tagalog
'Oku ke fiema'u tokoni 'iha lea makehe? Te mau malava 'o 'oatu ha fakatonulea ta'etotongi. Telefoni ki he <b>1-877-628-5076</b> 'o fakaha mai pe koe ha 'ae lea fakafonua 'oku ke ngaue'aki. (TTY: 1-855-585-8604 pe 711).	Tongan
Bạn có cần giúp đỡ bằng ngôn ngữ khác không ? Chúng tôi se yêu cầu một người thông dịch viên miễn phí cho bạn. Gọi <b>1-877-628-5076</b> nói cho chúng tôi biết bạn dùng ngôn ngữ nào. (TTY: 1-855-585-8604 hoặc 711).	Vietnamese Việt Nam
Gakinahanglan ka ba ug tabang sa imong pinulongan? Amo kang mahatagan ug libre nga maghuhubad. Tawag sa <b>1-877-628-5076</b> aron magpahibalo kung unsa ang imong sinulti-han. (TTY: 1-855-585-8604 o 711).	Visayan (Cebuano)

**NEED HELP WITH YOUR APPLICATION?** Visit <u>mybenefits.hawaii.gov</u> or call us at 1-877-628-5076. If you need help in a language other than English, call 1-877-628-5076 and tell the customer service representative the language you need. We will get you help at no cost to you. TTY/TDD users should call 1-855-585-8604.

# **STEP 1**

# Tell Us About Yourself.

(We need one adult in the family to be the contact person for this application.)

1.	First name	Middle name		Last name		Suffix	
2.	Home address (If you are homeless, pleas	se enter "homeless" h	here with approp	iate city, state and zip code)	3. Apartmer	t or suite number	
4.	City		5. State	6. ZIP code	7. County		
8. Mailing address (if different from home address)			1		9. Apartmer	nt or suite number	
10	. City		11. State	12. ZIP code	13. County		
14. Phone number ( ) –			•	15. Other phone numbe	r _		
16. Do you want to get information about this application by email? Yes No Email address:							
17. What is your preferred spoken language (if not English)?			18. What	18. What is your preferred written language (if not English)?			
19. How many family members live with you?		jailed)	<ul> <li>20. Is any family member you usually live with incarcerated (detained or jailed) or residing in the Hawaii State Hospital?</li> <li>Yes No</li> <li>If yes, please list their name(s):</li> </ul>		etained or		

# **STEP 2** Tell Us About Your Family.

**Complete this step for each person in your family.** Start with yourself, then add other adults and children. If you have more than two (2) people in your family, you will need to make a copy of <u>pages 4 and 5</u> for each additional person and attach the pages to this application.

You do not need to provide immigration status, but you may need to provide a Social Security Number (SSN) for family members with income who do not need health coverage. However, providing their SSN can help speed up the application process as we use SSNs to check income and other information to see who is eligible for help with health coverage costs; without their SSN, we may need to ask you for more information. We will keep all the information you provide private and secure as required by law.

# Who do you need to include on this application?

The following people should be included if they live with you or you are responsible for their care, even if they are temporarily away (college, deployment, etc.).

- You and your spouse (if married)
- Natural, adoptive, or step children under age 19 years old
- Unmarried partner
- Anyone you include on your tax return (even if they do not live with you)
- Anyone else you take care of under age 19 years old

NEED HELP WITH YOUR APPLICATION? Visit <u>mybenefits.hawaii.gov</u> or call us at 1-877-628-5076. If you need help in a language other than English, call 1-877-628-5076 and tell the customer service representative the language you need. We will get you help at no cost to you. TTY/TDD users should call 1-855-585-8604.

# STEP 2: PERSON 1 (Start With Yourself)

Complete Step 2 for yourself, your spouse/partner and children who live with you and/or anyone on your same federal income tax return if you file one. See page 1 for more information about who to include. If you do not file a tax return, remember to still add family members who live with you.

1.	First name	Middle name	Last na	me		Suffix	2. Relationship to P SELF	ERSON 1?	
3.	Date of birth (mm/dd/yyyy)			4. Gender:	Male Female		Name of spouse if marri	ed.	
6.	Social Security Number (S	SN)							
	We need this if you want health coverage and have an SSN. Providing your SSN can be helpful if you do not want health coverage too since it can speed up the application process. We use SSNs to check income and other information to see who is eligible for help with health coverage costs. If someone wants help getting an SSN, call 1-800-772-1213 or visit socialsecurity.gov. TTY users should call 1-800-325-0778.								
7.	Do you plan to file a federal income tax return NEXT YEAR? (You can still apply for health insurance even if you do not file a federal income tax return.)								
	Yes. If yes, please answer questions a-c.      No. If no, skip to question c.         a. Will you file jointly with a spouse?      Yes      No								
	If yes, write name of spouse:								
	<ul> <li>b. Will you claim any deperimental If yes, write name(s) of</li> </ul>	,	turn? 🗌 Yes	No					
	<ul> <li>Will you be claimed as</li> <li>If yes, write the name of How are you related to</li> </ul>	of the tax filer:	one's tax return?	Yes 🗌	No				
8. Are you pregnant? 🗌 Yes 🗌 No If yes, how many babies are expected during this pregnancy? Expected Due Date:									
9.	<ul> <li>Do you need health coverage? (Even if you have insurance, there might be a program with better coverage or lower costs.)</li> <li>Yes. If yes, answer all the questions below.</li> <li>No. If no, SKIP to the income questions on page 3. Leave the rest of this page blank.</li> </ul>								
10.	Do you have a disability			ths? 🗌 Yes		No			
	<ul> <li>a. Do you currently received</li> <li>b. Have you received to</li> <li>Yes. If yes, what of</li> </ul>	ng term care nursing dates(s)?	services in the las	t three (3) mon		No	home in the community	∐ No	
	<ul><li>c. Do you think you nee</li><li>d. Do you receive Supp</li></ul>	0	0	? L Yes		」No ]No			
11.	11. Did you receive any medical services in the past ten (10) calendar days immediately prior to the date of this application?         Yes. If yes, what date(s)?								
12. Are you a U.S. citizen or U.S. national? Yes. If yes, skip to Question 15.									
13. If you are not a U.S. citizen or U.S. national, do you have eligible imm Immigration document type (i.e. I-551, Visa, etc.) Status type (optional)					migration status? If Yes, enter document type and ID number. Write your name as it appears on your immigration document				
	5 JI (			, ,			, ,		
Alien or I-94 number				Passport	Passport number or other card number				
SEVIS ID or Expiration Date (optional)				Other (cat	Other (category code or country of issuance)				
14. Provide the date of entry to the U.S. found on your immigration document listed in question 13. (mm/dd/yyyy)									
a. Are you a citizen of the Federated States of Micronesia, Republic of Marshall Islands, or Republic of Palau?									
15	b. Are you, your spouse o				nilitary?	Yes	No		
<ul> <li>15. Were you in foster care at age 18 years or older in Hawaii? Yes No</li> <li>16. Are you a full-time student? Yes No</li> </ul>									
16. Are you a full-time student?       Yes       No         17. If Hispanic/Latino, ethnicity (OPTIONAL: mark all that apply.)									
Mexican Mexican American Chicano/a Puerto Rican Cuban Other									
18.	Race ( <b>OPTIONAL</b> : mark a	Il that apply) Black or African Amer	icon	Filipino		Vietnamese	🗌 Guamanian o	r Chamorra	
	Asian Indian	American Indian or Al		Japanese	_	Other Asian	Other Pacific		
	Chinese	Native Hawaiian		Korean		Samoan	Other:		
NEED HELP WITH YOUR APPLICATION? Visit <u>mybenefits.hawaii.gov</u> or call us at 1-877-628-5076. If you need help in a language other than English, call 1-877-628-5076 and tell the customer service representative the language you need. We will get you help at no cost to you. TTY/TDD users should call 1-855-585-8604.									
DH	you. 1117/100 users si IS 1100 (REV. 12/16) TN No: 16-0001	nouiu cali 1-000-080		roval Date: 04/	03/2017			Page <b>2</b> of <b>9</b>	

Approval Date: 04/03/2017 Paper Application - 4
# STEP 2: PERSON 1 (Continue With Yourself)

С	urrent Job & Inco	ome Inform	ation			
	Employed If you are currently employ your income. Start with q			employed o question 28.	Not employ Skip to ques	
	JRRENT JOB 1:	End	Data			
	Irt Date: Employer name and address:	End I	Date:		20. Employer ph	ione number:
					( )	_
21.	Wages/tips (before taxes):	Hourly	U Weekly	Every 2 weeks	Twice a month	Monthly
	\$					
22.	Average hours worked each \	VEEK:				
Сι	JRRENT JOB 2: (If you	have more job	s and need r	nore space, attach ar	nother sheet of pape	er.)
	rt Date:	End	Date:			
23.	Employer name and address:				24. Employer ph	ione number:
					( )	_
25.	Wages/tips (before taxes):	Hourly	U Weekly	Every 2 weeks	Twice a month	Monthly
26.	Average hours worked each \	VEEK:				
27.	Did you: Change jobs	Stop workin	ig 🗌 Star	t working fewer hours	□ None of these	
28.	If self-employed, answer the f a. Type of work:	ollowing questions:	t	<ul> <li>How much net income (p from this self-employments)</li> </ul>		
29.	OTHER INCOME THIS NOTE: You do not need to te				often you get it.	
	Unemployment \$_	How	v often?	_ Net farming/fi	shing \$	How often?
	Pensions \$_	How	often?	_ Net rental/roy	valty \$	How often?
	Social Security \$_	How	often?	_ Other income	\$	How often?
	Retirement accounts \$_	How	/ often?	_ Type of other	income:	
	Alimony received \$_	How	v often?	_		
30.	DEDUCTIONS: Check al If you pay for certain things th little lower. NOTE: You should not includ Alimony paid \$	at can be deducted	on a federal inco ready considered	me tax return, telling us abo in your answer to net self-e	mployment (question 28b	
	Student loan interest \$_				r deductions:	
31.	NET YEARLY INCOME If you do not expect change				th.	
	Your total income this year: \$		3	Your total income next year (	(if you think it will be differ	ent)
?	NEED HELP WITH YOUR	ore people to in Once comp APPLICATION? V	clude, please i bleted, attach a ïisit <u>mybenefits.</u> ł	we need to know make a copy of STEP 2: additional pages to this <u>nawaii.gov</u> or call us at 1-8' ce representative the lang	PERSON 2 (Pages 4 application. 77-628-5076. If you need	l help in a language other
	you. TTY/TDD users shou			ce representative the lang	uage you need. we will	Page 3 of 9

Effective Date 9/1/2016

# **STEP 2: PERSON 2**

Co	mplete Step 2 for additional hou	sehold members	other than Pl	ERSON 1.				
1.	First name	Middle name		Last name			Suffix	2. Relationship to PERSON 1?
3.	Date of birth (mm/dd/yyyy)		]/	4. G	ender:	Male Female	5. Name o	f spouse if married.
6.	Social Security Number (SSN)		·					
	We need this if PERSON 2 we since it can speed up the applic coverage costs.							do not want health coverage too eligible for help with health
7.	Does PERSON 2 live at the sa If no, write address:	me address as PI	ERSON 1?	Yes	🗌 No			
8.	Does PERSON 2 plan to file (You can still apply for health in				ne tax returr	ı.)		
	Yes If yes, please answ	•		□ No. If no, □ No	skip to qu	estion c.		
	a. Will PERSON 2 file jointly If yes, write name of spo	•						
	b. Will PERSON 2 claim any If yes, write name(s) of de		s/her tax retu	rm? 🗌 Yes	🗌 No			
	c. Will PERSON 2 be claimed If yes, write the name of the How is PERSON 2 related	ne tax filer:	on someone	's tax return	🗌 Yes	🗌 No		
9.	Is PERSON 2 pregnant?	Yes 🗌 No Ify	es, how mar	iy babies are ex	pected durir	ng this pregna	incy?	Expected Due Date:
10.	Does PERSON 2 need health Yes. If yes, answer all			insurance, there	No.		to the inco	me questions on page 5.
11.	Does PERSON 2 have a dis	•		. ,				
		l long term care you need long te	nursing serv erm care nu	vices in the last irsing services	three (3) r	nonths?		my home in the community <b>No</b> , what date(s)? <b>No</b>
12.	Did PERSON 2 receive any me Yes. If yes, what date(s)?		the past ten	(10) calendar da	ys immedia		e date of thi <b>No</b>	s application?
	Is PERSON 2 a U.S. citizen or			yes, skip to Que			No	
14.	If PERSON 2 is not a U.S. c			s he/she have	eligible imn	nigration stat	us?	
In	migration document type (i.e. l	-551, Visa, etc.)	Status type	e (optional)	-			our immigration document
Al	ien or I-94 number				Passport r	number or oth	er card num	ıber
SI	EVIS ID or Expiration Date (Opt	ional)			Other (cate	egory code or	country of	issuance)
	Provide the date of entry to a. Is PERSON 2 a citizen of <b>Yes No</b> b. Is PERSON 2, PERSON 2' Was PERSON 2 in foster care	f the 🗌 Federat	ed States o nt, a veteran	f Micronesia, [ or an active-dut	Republic	f the U.S. mili	Islands, or	
	Is PERSON 2 a full-time studer					•		
	If Hispanic/Latino, ethnicity ( <b>O</b> Mexican Mexican A	PTIONAL: mark a		.)	an ∏ C	uban 🗌 (	Other	
19.	Race (OPTIONAL: mark all the	at apply)						
		ack or African Am		∐ Filip				Guamanian or Chamorro
		nerican Indian or <i>i</i> ative Hawaiian	Alaska Malivi	e 🗌 Jap	anese ean	Other		Other Pacific Islander     Other:
			. tell us					2 on the back.
_	NEED HELP WITH YOUR A			-				bu need help in a language other
?								Ve will get you help at no cost to

you. TTY/TDD users should call 1-855-585-8604.

DHS 1100 (REV. 12/16) TN No: 16-0001 Supercedes TN No: 14-0008

## STEP 2: PERSON 2

C	urrent Job & Inco	me Inform	ation			
	Employed If PERSON 2 is currently emp about his/her income. Start 20.		Skip to question 29.		Not employ Skip to ques	
Сι	JRRENT JOB 1:					
	art Date:	End I	Date:			
20.	Employer name and address:				21. Employer ph (  )	none number: —
22.	Wages/tips (before taxes):	Hourly	U Weekly	Every 2 weeks	Twice a month	Monthly
23.	Average hours worked each W					
С	JRRENT JOB 2: (If PER	SON 2 has mo	re jobs and	l need more space, attac	h another sheet o	of paper.)
Sta	art Date:	End I	Date:			
24.	Employer name and address:				25. Employer ph	none number:
					( )	_
26.	Wages/tips (before taxes):	-	U Weekly	Every 2 weeks	Twice a month	Monthly
27.	Average hours worked each W	EEK:				
28.	Did PERSON 2: Change	e jobs 🗌 S	top working	Start working fewer hours	None of thes	е
	a. Type of work:			<ul> <li>b. How much net income (pro PERSON 2 get from this se</li> <li>\$</li></ul>	fit once business exper If-employment this mor	nth?
30.	OTHER INCOME THIS INOTE: You do not need to tell			and give the amount and how oft i's payment.	en PERSON 2 gets it.	
		How	•		ing \$	How often?
	Pensions \$_	How	often?	Net rental/royalt	y \$	How often?
	Social Security \$	How	often?	Other income	\$	How often?
	Retirement accounts \$	How	often?	Type of other in	come:	
	Alimony received \$	How	often?			
31.	If PERSON 2 pays for certain t coverage a little lower.	hings that can be o	leducted on a f	and how often PERSON 2 gets it. Tederal income tax return, telling u ed in your answer to net self-emp		
		How oft	-			low often?
	Student loan interest \$	How offe	en?	Type of other de	eductions:	
32		•		ncome changes a lot from month me, skip to the next section.	to month.	
	PERSON 2's total income this			PERSON 2's total income next	year (if you think it will	be different)
	\$			\$		
?	NEED HELP WITH YOUR A	If there are PPLICATION? V 3-5076 and tell the	no more peo isit <u>mybenefits</u> customer ser	ed to know about PE ople to include, skip to next <u>s.hawaii.gov</u> or call us at 1-877- rvice representative the languag	page. 628-5076. If you need	

## **Household Relationships**

List all the individuals included on this application and identify how each member is related to each other. Use the following relationships to identify relationships to household members.

Primary Individual

Married

• Uncle/Aunt

Name of Person 1:

STEP 3

• Under Primary Care Parent (including step)

**Household Member PERSON 1** 

- Child (including step) • Grandparent
  - Grandchild
    - Cousin
- Foster Parent
  - Not Related

• Sibling (including step)

- Unmarried Partner
- Niece/Nephew (including step) •

SEI E

Foster Child

			0221	
Household Member PERSON 2				
Name of Person 2:	Relationship to Person 1:			
Is Person 2 primarily responsible for the care of a child(ren) under age 19 years old in this household?       Yes, name of child(ren):         No				
Household Member PERSON 3				
Name of Person 3:	Relationship to Person 1:	Relationship to Person 2:		
Is Person 3 primarily responsible for the child(ren) under age 19 years old in this I		f child(ren):		
Household Member PERSON 4				

Name of Person 4:	Relationship	to Person 1:	Relationship to Person 2:	Relationship to Person 3:
Is Person 4 primarily responsible for the care of a child(ren) under age 19 years old in this household?		☐ Yes, name ☐ No	of child(ren):	

Household Member PERSON 5					
Name of Person 5:	Relationship to Persor	1: Relationship to Perso	on 2: Relationship to Person 3:		
Relationship to Person 4:					
Is Person 5 primarily responsible for th child(ren) under age 19 years old in this		name of child(ren):			

Household Member PERSon 6				
Name of Person 6:	Relationship t	o Person 1:	Relationship to Person 2:	Relationship to Person 3:
Relationship to Person 4:			Relationship to Person 5:	
· · · · · · · · · · · · · · · · · · ·				
Is Person 6 primarily responsible for th	e care of a	🗌 Yes, name	of child(ren):	
child(ren) under age 19 years old in this	s household?	□ No	· · ·	

If you have more than (6) people in your family, you will need to make a copy of this page and begin with PERSON 2 and attach to this application.

?

NEED HELP WITH YOUR APPLICATION? Visit mybenefits.hawaii.gov or call us at 1-877-628-5076. If you need help in a language other than English, call 1-877-628-5076 and tell the customer service representative the language you need. We will get you help at no cost to you. TTY/TDD users should call 1-855-585-8604.

ald Mambar DEDCON 6

#### STEP 4 American Indian Or Alaska Native (Al/AN) Family Member(s)

Are you or is anyone in your family American Indian or Alaska Native? 1.

Yes. If yes, go to Appendix B.

No. If No, skip to Step 5.

ST

□ No

3.

ΈΡ

## Your Family's Health Coverage

For every year that you got a premium tax credit, did your household file a tax return and reconcile any premium tax credit you used? 1.

Yes, premium tax credits were reconciled. Check this box only if ALL of these below apply to you:

- You used advance payments of premium tax credits (APTC) in one or more past years to help lower your costs for Marketplace coverage.
- The tax filer for your household filed a federal income tax return for each of these years.
- . The tax return filed compared the amount of APTC used to the rest of the tax return information for each year.

Was anyone on this application found not eligible for Medicaid or CHIP in the past 90 days? (Select yes only if someone was found not eligible
for this coverage by Med-QUEST, not by the Marketplace.)

Yes	Who:	
🗌 No		
Was any	one on	this application found not eligible for Medicaid or CHIP due to their immigration status since October 1, 2013?

	Yes Who:
4	Did anyone on this application apply for coverage during the Marketplace open enrollment period?

	, ist setterage aaning the mainer	place open entennent period i

5.	Is anyone listed on this application offered health coverage from a job? Check yes even if the coverage is from someone else's job. Like a

	Yes	Continue and then complete Appendix A. Is this a state employee benefit plan?	Yes	🗌 No
$\square$	No			

Is anyone enrolled in health coverage now? 6.

parent or spouse, even if they do not accept the coverage.

Yes If yes, continue to question 7 (Information about current health covera
-----------------------------------------------------------------------------

□ No If no, SKIP to Step 6.

7. Information about current health coverage. (If you have more than 6 people who have health coverage now, make a copy of the next page (page 8), begin with PERSON 2 and attach to this application.)

Family Health Coverage PERSON 1							
Name of person 1 enrolled in health coverage:							
Type of Coverage(s): Employer Insurance COBRA Medicaid CHIP Medicare TRICARE VA health care program Peace Corps Other							
If it is an employer insurance: (You will also need to complete Appendix A.) Policy/ID number							
Name of health insurance company:							
If it is another kind of coverage:	·						
Name of health insurance company:	Policy/ID number						
Is this a limited-benefit plan, like a school accident policy?	Includes Medical? Includes Dental? Includes Vision?						
NEED HELP WITH YOUR APPLICATION? Visit mybenefits.hawaii.gov	or call us at 1-877-628-5076. If you need help in a language other						

than English, call 1-877-628-5076 and tell the customer service representative the language you need. We will get you help at no cost to you. TTY/TDD users should call 1-855-585-8604.

ype of Coverage(s): Employer Insurance COBRA Medicaid CHIP Mec	
it is an employer insurance: (You will also need to complete Appendix A.)	Policy/ID number
ame of health insurance company:	
it is another kind of coverage:	
ame of health insurance company:	Policy/ID number
this a limited-benefit plan, like a school accident policy?  Yes No	Includes Medical? Includes Dental? Includes Vision?
amily Health Coverage PERSON 3	
ame of person 3 enrolled in health coverage:	
rpe of Coverage(s): Employer Insurance COBRA Medicaid CHIP	iicare TRICARE VA health care program Peace Corps Other
it is an employer insurance: (You will also need to complete Appendix A.)	Policy/ID number
ame of health insurance company:	
it is another kind of coverage:	
ame of health insurance company:	Policy/ID number
this a limited-benefit plan, like a school accident policy?  Yes No	Includes Medical? Includes Dental? Includes Vision?
amily Health Coverage PERSON 4	
ame of person 4 enrolled in health coverage:	
pe of Coverage(s): Employer Insurance COBRA Medicaid CHIP Mec	licare TRICARE VA health care program Peace Corps Other
t is an employer insurance: (You will also need to complete Appendix A.)	Policy/ID number
ame of health insurance company:	
it is another kind of coverage:	
ame of health insurance company:	Policy/ID number
this a limited-benefit plan, like a school accident policy?  Yes No	Includes Medical? Includes Dental? Includes Vision?
amily Health Coverage PERSON 5	
ame of person 5 enrolled in health coverage:	
pe of Coverage(s): Employer Insurance COBRA Medicaid CHIP Medicaid	licare TRICARE VA health care program Peace Corps Other
it is an employer insurance: (You will also need to complete Appendix A.)	Policy/ID number
ame of health insurance company:	
it is another kind of coverage:	
ame of health insurance company:	Policy/ID number
this a limited-benefit plan, like a school accident policy?  Yes No	Includes Medical? Includes Dental? Includes Vision?
amily Health Coverage PERSON 6	
ame of person 6 enrolled in health coverage:	
rpe of Coverage(s): Employer Insurance COBRA Medicaid CHIP Mec	licare TRICARE VA health care program Peace Corps Othe
it is an employer insurance: (You will also need to complete Appendix A.)	Policy/ID number
ame of health insurance company:	
it is another kind of coverage:	
	Policy/ID number
ame of health insurance company:	

## **!!!SIGNATURE REQUIRED BELOW!!!**

## **STEP 6** Read & Sign This Application

- I am signing this application under penalty of perjury which means, I have 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 provide false and/or untrue information.
- I understand I must tell the Department of Human Services or the Federal Health Insurance Marketplace if anything changes (and is different than) what I wrote on this application. I can visit <u>mybenefits.hawaii.gov</u> or call 1-877-628-5076 (TTY/TDD: 1-855-585-8604) or visit <u>www.healthcare.gov</u> or call 1-800-318-2596 (TTY: 1-855-889-4325) to report any changes. I understand that a change in my household's information could affect the eligibility for member(s) of my household.
- I understand that under federal law, discrimination is not permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, or disability. I can file a complaint of discrimination by visiting www.hhs.gov/ocr/office/file.
- I understand the Department of Human services and the Federal Health Insurance Marketplace will obtain information to verify eligibility with
  electronic databases, to include but not limited to, the Internal Revenue Services (IRS), Social Security Administration (SSA), Department of
  Homeland Security (DHS) or a consumer reporting agency. If the information does not match, we may ask to you send us proof.

### Renewal of coverage in future years

To make it easier to determine my eligibility for help paying for health coverage in future years, I agree to allow the Federal Health Insurance Marketplace to use income data, including information from tax returns. The Federal Health Insurance Marketplace will send me a notice, let me make any changes, and I can opt out at any time.

Yes, renew my eligibility automatically for the next:

5 years (the maximum number of years allowed), or for a shorter number of years:

4 years 3 years 2 years

1 vears

Do not use information from tax returns to renew my coverage.

## If anyone on this application is eligible for Medicaid.

- I am assigning the Department of Human Services, my rights to payments for medical care from any third party, which may include but
  not limited to, other health insurance or legal settlement. I am also assigning the Department of Human Services, my rights to pursue and
  get medical support from a spouse or parent. I will cooperate in obtaining third party payments.
- Does any child on this application have a parent living outside of the home? Yes No If yes, I understand I will be asked to cooperate with the Department of Human Services and the agency that collects medical support from an absent parent. If I think that cooperating to collect medical support will harm me or my children, I can tell Medicaid and I may not have to cooperate.
- I agree to cooperate with the Department of Human Services, Federal Quality Control reviewers or auditors if my case is selected for a review.

### My right to appeal

If I think the Department of Human Services or the Federal Health Insurance Marketplace has made a mistake, I can appeal its decision. To appeal means to tell someone at the Department of Human Services or the Federal Health Insurance Marketplace that I think the action is wrong, and 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** (TTY/TDD: 1-855-585-8604). I know that I can be represented in the process by someone other than myself. My eligibility and other information will be explained to me.

**Sign this application.** The person who filled out Step 1 should sign this application. If you are an authorized representative, you may sign here with your name, as long as you have provided the information required in Appendix C.

Signature		Date (mm/dd/yyyy)
STEP 7	Mail Your Signed Application To:	

MQD/EB

Oahu Section P.O. Box 3490 Honolulu, HI 96811-3490

MQD/EB

Lanai Unit P.O. Box 1619 Kaunakakai, HI 96748-1619 MQD/EB Kapolei Unit

P.O. Box 29920

Honolulu, HI 96820-2320

MQD/EB

Maui Section

Millyard Plaza

210 Imi Kala Street, Suite 101

Wailuku, HI 96793-1274

MQD/EB

East Hawaii Section 1404 Kilauea Avenue Hilo, HI 96720-4670

MQD/EB

Molokai Unit P.O. Box 1619 Kaunakakai, HI 96748-1619 MQD/EB

West Hawaii Section Lanihau Professional Center 75-5591 Palani Road, Suite 3004 Kailua-Kona, HI 96740-3633

MQD/EB

Kauai Section 4473 Pahee Street, Suite A Lihue, HI 96766-2037

If you want to register to vote, you can complete the attached voter registration form or download a form from http://elections.hawaii.gov

NEED HELP WITH YOUR APPLICATION? Visit <u>mybenefits.hawaii.gov</u> or call us at 1-877-628-5076. If you need help in a language other than English, call 1-877-628-5076 and tell the customer service representative the language you need. We will get you help at no cost to you. TTY/TDD users should call 1-855-585-8604.

## Health Coverage from Jobs

You do not need to answer these questions unless someone in the household is eligible for health coverage from a job. Attach a copy of this page for each job that offers coverage.

#### Tell us about the job that offers coverage.

Take the Employer Coverage Tool on the next page to the employer who offers coverage to help you answer these questions. You only need to include this page when you send in your application, not the Employer Coverage Tool.

# EMPLOYEE Information The employee needs to fill out this section.

1. Employee name (First, Middle, Last)			2. Employee Social Security Number
EMPLOYER Informatio	n		
3. Employer name			4. Employer Identification Number (EIN)
5. Employer address (notice will be sent to this address	s)		6. Employer phone number ( ) –
7. City	8. State		9. ZIP Code
10. Who can we contact about employee health at this j	ob?		
11. Phone number (if different from above) ( ) –		12. Email address	
<ul> <li>13. Are you currently eligible for coverage offered by thi</li> <li>Yes (continue)</li> </ul>	s employer, or will you be	come eligible in the n	ext three (3) months?
a. If you are in a waiting or probationary period	, , , , , , , , , , , , , , , , , , ,	overage?	mm/dd/yyyy
List the names of anyone else who is eligible for	or coverage from this job.		
Name:	Name:		Name:
<b>No (STOP</b> and go to Step 6 in the application)			

### Tell us about the health plan offered by this employer.

14. Describe employer effer a health plan that master the minimum value standard*2
14. Does the employer offer a health plan that meets the minimum value standard*?
15. For the lowest-cost plan that meets the minimum value standard* offered only to the employee (do not include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/she received the maximum discount for any tobacco cessation program, and did not receive any other discounts based on wellness programs.
a. How much would the employee have to pay in premiums for this plan? \$
b. How often? 🗌 Weekly 📄 Every 2 weeks 📄 Twice a month 📄 Once a month 📄 Quarterly 📄 Yearly
<ul> <li>16. What change will the employer make for the new year (if known)?</li> <li>Employer will not offer health coverage.</li> <li>Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15) <ul> <li>a. How much will the employee have to pay in premiums for that plan?</li> <li>b. How often?</li> <li>Weekly</li> <li>Every 2 weeks</li> <li>Twice a month</li> <li>Once a month</li> <li>Quarterly</li> <li>Yearly</li> </ul> </li> </ul>
*An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit cost covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

NEED HELP WITH YOUR APPLICATION? Visit mybenefits.hawaii.gov or call us at 1-877-628-5076. If you need help in a language other A than English, call 1-877-628-5076 and tell the customer service representative the language you need. We will get you help at no cost to you. TTY/TDD users should call 1-855-585-8604.

## EMPLOYER COVERAGE TOOL

Use this tool to help answer questions in Appendix A about any employer health coverage that you are eligible for (even if it is from another person's job, like a parent or spouse). The information in the numbered boxes below need to match the boxes on Appendix A. For example, the answer to question 14 on this page should match question 14 on Appendix A.

Write your name and Social Security number in boxes 1 and 2 and ask the employer to fill out the rest of the form. Complete one tool for each employer that offers health coverage.

	7	J	

## **EMPLOYEE** Information

The employee needs to fill out this section.

1. Employee name (First, Middle, Last)			2 Fm	olovee	e Social	Securit	v Num	ber	
EMPLOYER Information Ask the employer for this section.	1								
3. Employer name			4. E	mploy	er Ident	ification	Num	ber (E	IN)
5. Employer address (notice will be sent to this address	)		6. E	mploy	er phon	e numb	er		
			(		)	—			
7. City	8. State		9. Z	IP Co	de				
10. Who can we contact about employee health coverage	e at this job?								
11. Phone number (if different from above)		12. Email address							
( ) –									
13. Are you currently eligible for coverage offered by this Yes (continue)	employer, or will you be	come eligible in the ne	ext three	e (3) r	nonths?	>			
a. If the employee is not eligible today, including	as a result of a waiting	or probationary period,	when	is the	employ	ee eligit	ole for	cover	age?
mm/dd/yyyy (continue)									
No (STOP and go to Step 6 in the application)									
Tell us about the health plan offered by this e	mployer.								
Does the employer offer a health plan that covers an en Yes Which people?  Spouse  Dep No	nployee's spouse or dep bendent(s)	endent?							
(Go to question 14)									
14. Does the employer offer a health plan that meets the	minimum value standard	*?							
Yes No									
15. For the lowest-cost plan that meets the minimum value standard* offered only to the employee (do not include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/she received the maximum discount for any tobacco cessation program, and did not receive any other discounts based on wellness programs.									
a. How much would the employee have to pay in premiums for this plan? \$									
b. How often?  Weekly Every 2 weeks Twice a month Once a month Vearly Yearly									
<ul> <li>16. What change will the employer make for the new yea</li> <li>Employer will not offer health coverage.</li> <li>Employer will start offering health coverage to emmeets the minimum value standard. *(Premium sa. How much will the employee have to pay in pro-</li> </ul>	ployees or change the p hould reflect the discou						he em	ploye	e that
b. How often?	Twice a month	Once a month	Quarte	rly [	] Yearl	у			
Date of change (mm/dd/yyyy):									
*An employer-sponsored health plan meets the "minimum value standard"	if the plan's share of the total al	lowed benefit cost covered by	the plan	is no les	ss than 60	percent o	f such co	osts (Se	ction
36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)									

NEED HELP WITH YOUR APPLICATION? Visit <u>mybenefits.hawaii.gov</u> or call us at 1-877-628-5076. If you need help in a language other than English, call 1-877-628-5076 and tell the customer service representative the language you need. We will get you help at no cost to you. TTY/TDD users should call 1-855-585-8604.

7

## American Indian Or Alaska Native Family Member (AI/AN)

Complete this appendix if you or a family member are American Indian or Alaska Native. Submit this with your Application for Health Coverage & Help Paying Costs.

Tell us about your American Indian or Alaska Native family member(s).

American Indians and Alaska Natives can get services from the Indian Health Services, tribal health program, or urban Indian health programs. They also may not have to pay cost sharing and may get special monthly enrollment periods. Answer the following questions to make sure your family gets the most help possible.

### NOTE: If you have more people to include, make a copy of this page and attach.

	AI/AN PERSON 1	AI/AN PERSON 2
1. Name (First name, Middle name, Last name)	First Middle	First Middle
	Last	Last
2. Member of a federally recognized tribe?	Yes If yes, tribe name is: No	<ul> <li>Yes If yes, tribe name is:</li> <li>No</li> </ul>
		_
<ol> <li>Has this person ever gotten a service from the Indian Health Service, a tribal health program, urban Indian health program, or</li> </ol>	<ul> <li>Yes</li> <li>No If no, is this person eligible to get</li> </ul>	<ul> <li>Yes</li> <li>No If no, is this person eligible to get</li> </ul>
through a referral from one of these programs?	services from the Indian Health services, tribal health programs, urban Indian health programs, or through a referral from one of these programs?	services from the Indian Health services, tribal health programs, urban Indian health programs, or through a referral from one of these programs?
	🗌 Yes 🔲 No	🗌 Yes 🔲 No
<ol> <li>Certain money received may not be counted for Medicaid or the Children's Health Insurance Program (CHIP). List any income (amount and how often) reported on your application that includes money from these sources:</li> </ol>	\$ How often?	\$ How often?
<ul> <li>Per capita payments from a tribe that come from natural resources, usage rights, leases, or royalties.</li> </ul>		
<ul> <li>Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior (including reservations and former reservations).</li> </ul>		
<ul> <li>Money from selling things that have cultural significance.</li> </ul>		



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## Assistance With Completing This Application

#### You can choose an authorized representative.

You can give a trusted person permission to talk about this application with us, see your information, and act for you on matters related to this application, including getting information about your application and signing your application on your behalf. This person is called an "Authorized Representative." If you ever need to change your Authorized Representative, call 1-877-628-5076. If you are a legally appointed representative for someone on this application, submit proof with the application.

#### 1. Name of authorized representative (First name, Middle name, Last name)

2. Mailing Address			3. Apartment or suite number
4. City	5. State	6. ZIP code	7. County
8. Phone number ( ) –	I		
9. Organization name			10. ID number (if applicable)

By signing, you allow this person to sign your application, get official information about this application, and act for you on all future matters with this agency.

11. PERSON 1 or Primary I	Individual's	Signature
---------------------------	--------------	-----------

### Authorized Representative

As the designated Authorized Representative, by signing below I agree to maintain the confidentiality of any information provided to me by the Department or it's designee and I can be released as the Authorized Representative:

	Signature of Authorized Representative		Telephone	Date
	Mailing Address	City	State	ZIP Code
As applicable, I			, am a provider or staff	member or volunteer
	PRINT Name of Individu	al		
of an organization:				
	PRINT Name of Provider/Orga	nization		
I understand and any	an an a condition of coming on the Auti	a nima di Damasa a nta		requiations relating to
confidentiality of info or an organization ac	ree, as a condition of serving as the Aut ormation and the prohibition against rea sting on the facility's behalf, as well as o ntiality of information.	ssignment of prov	ider claims as appropriat	e for a health facility
confidentiality of info or an organization ac interest and confiden	ormation and the prohibition against rea cting on the facility's behalf, as well as c	ssignment of prov ther relevant State	ider claims as appropriat and Federal laws covering	e for a health facility
confidentiality of info or an organization ac interest and confiden For certified applic Complete this section if y	ormation and the prohibition against reacting on the facility's behalf, as well as ontiality of information. Tation counselors, navigators, agen ou are a certified application counselor, navigator	ssignment of prov ther relevant State s, and brokers o	ider claims as appropriat and Federal laws coveri only	e for a health facility ng conflicts of
confidentiality of info or an organization ac interest and confiden For certified applic	ormation and the prohibition against reacting on the facility's behalf, as well as ontiality of information. Tation counselors, navigators, agen ou are a certified application counselor, navigator	ssignment of prov ther relevant State s, and brokers o	ider claims as appropriat and Federal laws coveri only	e for a health facility ng conflicts of
confidentiality of info or an organization ac interest and confiden For certified applic Complete this section if y	ormation and the prohibition against reacting on the facility's behalf, as well as on initiality of information. Eation counselors, navigators, agen ou are a certified application counselor, navigato (mm/dd/yyyy)	ssignment of prov ther relevant State s, and brokers o	ider claims as appropriat and Federal laws coveri only	e for a health facility ng conflicts of

Approval Date: 04/03/2017 Paper Application - 15 12. Date (mm/dd/yyyy)

nans. No. 74_ Ses approval: 2/23/

Revision: MSA-PI-75-3 August 20, 1974

Attachment 2.6-B

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State HAWAII

STANDARDS FOR OPTIONAL STATE SUPPLEMENTARY PAYMENTS

Aged, blind, and disabled recipients of optional State supplementary L. payments are eligible for medical assistance as categorically needy under this plan. The payments meet the four conditions specified in 45 CFR 248.2(d), that is, they are: Regular, in cash, and based on need; A. Available on a Statewide basis; в. C. Made to reasonable classifications of individuals who, except for the level of their income, would be eligible for an SSI payment, as described in the supplement to this ATTACHMENT; and Equal to the difference between income and the financial standard D. used to determine eligibility for the supplement. There are variations in the payment levels by political subdivisions. II. No. /x/ Yes, as described below:

## Revision: HCFA-AT-80-58 August, 1980

Attachment 2.6-C Page 6

State of HAWAII

- 2. The method(s) checked below is used in handling resources in excess of those specified above:
  - Excess non-income producing property (except the home) must be disposed of

Any excess resources render the individual ineligible

Other, described as follows:

OHEW Trans. No.	MCAS	80-18	
DHEW Trans. No.	Dec 77	1980	
Trans. Date DHEW Approval .	FER	0.9 (83)	