ATT	ACE	171	2.2-A
Page	2		

State:	Rewa	H
Agency ⁴ Citation(s)	Gra	ups Covered
	Mandatory Covera Required Special G	er - Categorically Needy and Other regum (Continued)
*	2. Deemed Recip	ients of AFDC
1902 (a)(10)(A)(1)(1) of the Act	supplement any child of individual fadividual there were	Actober 1, 1990, participants in a work station program under title IV-A and or relative of such individual (or other living in the same household as such a) who would be eligible for AFDC if one work supplementation program, in a with section 482 (c)(6) of the Act.
482 (a)(22)(A) of the Act		s whose AFDC payment are reduced to seen of recovery of overpayment of da.
405(h) and 1902(a)(10)(A) (l)(l) of the Act	for a perio family bec collection	ace unit decined to be receiving AFDC d of four calendar months because the ones ineligible for AFDC as a result of or increased collection of support and requirements of section 406(h) of the
1902(a) of the Act	meet the re for whom effect or fo	s deemed to be receiving AFDC who equirements of section 473(b)(1) or (2) an adoption assistance agreement is in oter care maintenance payments are a under title IV-E of the Act.
		plement 15 to Attachment 2.6-A for under section 1931 of the Act.

MIN. OF IRMININ

* Agency that determines eligibility for coverage.

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

Effective Date_____IUL____ 1991

Revision:	HCFA-PM-91 August 1991	4 (BPD)		ATTACHMENT Page 2a OMB NO.:	
	State:	HAWAII	HAWAII		
Agency*	Citation(s)		Groups Cover	red	
	۸.	Mandatory Coverage Required Special G	- Categorical Coups (Continu	lly Needy ar led)	d Other
407(b), 1 (a)(10)(A	902	3. Qualified Family	Members		
and 1905(m)(1) '	Effective Octobe	r 1, 1990, qu	alified	
of the Ac	c	family members w receive AFDC und			t
		because the prin unemployed.			

(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 No91-21	Approval Date	10/13/92	Effective	Date	0/01/91
Supersedes TN No. <u>88-15</u>			HCFA ID:	7983E	•

N

 \mathbb{C}

(Ç

.

I

ł

the survey are survey the state

Revision: HCFA-PH-92-1 FEBRUARY 1992	(HB)		ATTACHMENT 2 Page 5	.2-2
STATE PLAN	UNDER TITL	E XIX OF THE SOC	IAL SECURITY ACT	
State:	HAWAII		2 V	
COVERA	CE AND CON	DITIONS OF BLIGI	BILITY	
Citation(=)		Groups C	overed	
λ	. Mandato Require	ory Coverage - Ca d Special Groups	(Continued)	Other
1902(a)(10) (A)(1)(V) and 1905(m) of the Act Duplicates item on page Za, per MRM 42-10.	men	bers of a family bers of a family of under section not exercised ((b)(2)(5)(1) of	han qualified pregnant item A.7. above who ar that would be receivi 407 of the Act if the he option under sectio the Act to limit the n family may receive APD	ng State m number o
1902(e)(5) of the Act	11. a.	for, applied for the approved St pregnancy ends eligible, as the all pregnancy- assistance undo (beginning on the	ile pregnant, was elig or, and receives Medica ate plan on the day he bough she were pregnant celated and postpartum or the plan for a 60-day the last day of her pre- maining days in the mor- day falls.	to be to be for medical ay perior equancy)
1902(e)(6) of the Act	þ.	eligibility be (of the family during the pre which extends	an who would otherwise cause of an increase in in which she is a memb gnancy or the postparts through the end of the ay period (beginning of egnancy) ends.	n income ber) um periox month is
	<i>e</i>	*		

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

TN No.	00-006		1			A 190		0000
Supersedes	3	Approval Date: JUL	11	2000	Effective Dat	e: APH	-1	2000
TN No.	88-16	·			HCFA ID:	7983E		

Revision:

HCFA-PM-91-4 (BPD)

August 1991

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

* *	State:	
Agency*	Citation(s)	Groups Covered
		<u>Mandatory Coverage – Categorically Needy and Other</u> <u>Required Special Groups</u> (Continued)
42 CFR 435.120		 13. ☑ b. Individuals who meet more restrictive requirements for Medicaid than the SSI requirements. (This includes persons who qualify for benefits under section 1619(a) of the Act or who meet the requirements for SSI status under section 1619(b)(1) of the Act and who met the State's more restrictive requirements for Medicaid in the month before the month they qualified for SSI under section 1619(a) or met the requirements under section 1619(b)(1) of the Act. Medicaid eligibility for these individuals continues as long as they continue to meet the 1619(a) eligibility standard or the requirements of section 1619(b) of the Act.)
		✓ Aged
		J Blind
		J Disabled
		The more restrictive categorical eligibility criteria are described below:
		* Definition of disability as defined in 42 C.F.R. 435.540 and 435.541
		* Definition of blindness as defined in 42 C.F.R. 435.530 and 435.531
		(Financial criteria are described in <u>ATTACHMENT 2.6-A</u>).

TN No. 01-011	DEC	0.0.0001		TOO	۰.	0001
Supersedes	Approval Date:DEC	20 2001	Effective Date:	OCT	1	2001
TN No. 00-006			HCFA ID: 79	83E		

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

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

*	State:	HAWAII
Agency*	Citation(s)	Groups Covered
	А.	Mandatory Coverage – Categorically Needy and Other Required Special Groups (Continued)
1902(a) (10)(A)	,	14. Qualified severely impaired blind and disabled individuals under age 65, who
(i)(II) and 1905 of(q) of the 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 Act 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;
*		 Have unearned income in amounts that would not cause them to be ineligible for a payment under section 1611(b) of the Act;

TN No. 00-006	1111	1 4			
Supersedes	Approval Date: JUL	11 2000	Effective Date	E: NDD	1 2000
TN No. 86-16			HCFA ID:	7983E	

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

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

	State:	HAWAII	
Agency*	Citation(s)	Gr	oups Covered
•	А.		age – Categorically Needy and Other 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 eithe does not make SSP payments or does not provide Medicaid to SSP-only recipients.
7 		• 2	

TN No.	00-006						
Supersedes	3	Approval Date: UL	11 0	Effective Da	te: APR	1	2000
TN No.	86-16		1.	HCFA ID:	7983E		

Revision:	HCFA-PM-91-4 AUGUST 1991	(BPD)	ATTACHMENT 2.2-A Page 6d OHB NO.: 0938-
	State: <u>R</u>	WAII	
Agency*	Citation(S)	Grou	aps Covered
	λ.	Mandatory Coverage - Required Special Grou	Categorically Needy and Other 108 (Continued)
1619(b of the		requirements for Medi under 42 CFR 435.121. benefits under section individuals described requirements for SSI 1619(b)(1) of the Act restrictive requirements month they qualified met the requirements are covered. Eligibit continues as long as	re restrictive eligibility icaid than under SSI and Individuals who qualify for on 1619(a) of the Act or i above who meet the eligibility benefits under section t and who met the State's more ents in the month before the for SSI under section 1619(a) or of section 1619(b)(1) of the Act ility for these individuals they continue to qualify for on 1619(a) of the Act or meet the

TN No. 91-21	Approval Date 10/13/02	Effective Date 10/01/91
Supersedes		
TN NO.		HCFA ID: 79838

Kev 1910	HCFA-PM-91- AUCUST 1991		(BPD)		ATTACHMENT 2 Page 60 OMB NO.: 09	
	State:	HAWA	<u>II</u>			
Agency*	Citation(s)			Groups C	overed	
	λ.	Man	datory (uired S	<u>Coverage - Cate</u> Decial Groups (corically Needy a Continued)	nd Other
1634() the A		15.	eligibi	lity requiremen	apply more restricts for Medicaid the individuals who-	han unde
	1		a. Are	at least 18 yea	rs of age;	
ł			enti sect: these Medic cont:	tled to OASDI c lon 202(d) of t benefits base caid eligibilit lnues for as lo	y because they be hild's benefits un he Act or an incre d on their disabi- y for these indiv- ng as they would h ir OASDI eligibi-	nder ease in lity. iduals be eligi
		ل <u>ت</u> ر	requi all c cause incre amour	irements than t of the amount o od SSI/SSP inel bases are deduc	ore restrictive en hose under SSI, and f the OASDI benefing igibility and submitted when determining income for catego	nd part it that sequent ing the
			than benef of co	those under SS it is deducted	ore restrictive ro I, and none of the in determining the for categorically	
42 CF	R 435.122	16.	eligibi: SSI, inc optional Medicaid	lity requiremen iividuals who a l State supplem i under §435.23	apply more restricts ts for Medicaid the re ineligible for ents (if the agene 0), because of rear r title XIX of the	han unde SSI or Cy provi Quiremen
42 CF	R 435.130	17.	Individ	als receiving	mandatory State s	
*Agency th	nat determine	es eliç	jibility	for coverage.		
TN No. 91	-21 ADE	proval	Date 1	0/13/92 E	ffective Date	0/5

C

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

1

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

State: HAWAII

Agency* Citation(s)

Groups Covered

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

42 CFR 435.131

- 18. 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.
 - 1/X/ In December 1973, Medicaid coverage of the essential spouse was limited to the following group(s):

<u>x</u> Aged <u>x</u> Blind <u>x</u> Disabled

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

	Approval Dat	• _10/13/92	Effective Date 10/01/
Supersedes TN No.			HCFA ID: 7983E

State: HAWAII	Revision:	HCFA-PM-91- August 1991	- 4	(BPD)		ATTACHMENT 2.2-A Page 6g OMB NO.: 0938-
 A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued) 42 CFR 435.132 19. Institutionalized individuals who were eligible for Medicaid in December 1973 as inpatients of title XIX medical institutions or residents of title XIX intermediate care facilities, if, for each consecutive month after December 1973, the A. Continue to meet the December 1973 Medicaid State plan eligibility requirements; and b. Remain institutionalized; and c. Continue to need institutional care. 42 CFR 435.133 20. Blind and disabled individuals who e. Meet all current requirements for Medicaid eligibility except the blindness or disabili criteria; and b. Were eligible for Medicaid in December 1973 blind or disabled; and c. For each consecutive month after December 1973 		State:	HAV	AII		
Required Special Groups (Continued) 42 CFR 435.132 19. Institutionalized individuals who were eligible for Medicaid in December 1973 as inpatients of title XIX medical institutions or residents of title XIX medical institutions or residents of title XIX intermediate care facilities, if, for each consecutive month after December 1973, the A. Continue to meet the December 1973 Medicaid State plan eligibility requirements; and b. Remain institutionalized; and c. Continue to need institutional care. 42 CFR 435.133 20. Blind and disabled individuals who 4. Neet all current requirements for Medicaid eligibility except the blindness or disabled individuals who 6. Neet all current requirements for Medicaid eligibility except the blindness or disabled individuals who 6. Neet eligible for Medicaid in December 1973 blind or disabled; and 7. For each consecutive month after December 1973 blind or disabled; and	Agency*	Citation(s)			Groups (Covered
for Medicaid in December 1973 as inpatients of title XIX medical institutions or residents of title XIX intermediate care facilities, if, fo each consecutive month after December 1973, th a. Continue to meet the December 1973 Medicaid State plan eligibility requirements; and b. Remain institutionalized; and c. Continue to need institutional care. 42 CFR 435.133 20. Blind and disabled individuals who a. Meet all current requirements for Medicaid eligibility except the blindness or disabil criteria; and b. Were eligible for Medicaid in December 1973 blind or disabled; and c. For each consecutive month after December 1 continue to meet December 1973 eligibility			Mandal Reguli	tory Cove	al Groups (Con	cically Needy and Other stinued)
State plan eligibility requirements; and b. Remain institutionalized; and c. Continue to need institutional care. 42 CFR 435.133 20. Blind and disabled individuals who a. Meet all current requirements for Medicaid eligibility except the blindness or disabil criteria; and b. Were eligible for Medicaid in December 1973 blind or disabled; and c. For each consecutive month after December 1 continue to meet December 1973 eligibility	42 CFI	R 435.132 · I	19.	for Medi title XI title XI	caid in Decemb X medical inst X intermediate	per 1973 as inpatients of itutions or residents of care facilities, if, for
 C. Continue to need institutional care. 42 CFR 435.133 20. Blind and disabled individuals who a. Meet all current requirements for Medicaid eligibility except the blindness or disabilicriteria; and b. Were eligible for Medicaid in December 1973 blind or disabled; and c. For each consecutive month after December 1 continue to meet December 1973 eligibility 						
 42 CFR 435.133 20. Blind and disabled individuals who a. Meet all current requirements for Medicaid eligibility except the blindness or disabilicriteria; and b. Were eligible for Medicaid in December 1973 blind or disabled; and c. For each consecutive month after December 1 continue to meet December 1973 eligibility 				b. Remai	in institution	alized; and
 a. Meet all current requirements for Medicaid eligibility except the blindness or disabil criteria; and b. Were eligible for Medicaid in December 1973 blind or disabled; and c. For each consecutive month after December 1 continue to meet December 1973 eligibility 				c. Conti	nue to need in	nstitutional care.
eligibility except the blindness or disabil criteria; and b. Were eligible for Medicaid in December 1973 blind or disabled; and c. For each consecutive month after December 1 continue to meet December 1973 eligibility	42 CF	R 435.133	20.	Blind an	d disabled in	lividuals who
blind or disabled; and c. For each consecutive month after December 1 continue to meet December 1973 eligibility				eligi	bility except	equirements for Medicaid the blindness or disabilit
continue to meet December 1973 eligibility				b. Were blind	eligible for i or disabled;	fedicaid in December 1973 a and
				conti	inue to meet D	

TH No. 91-21	Approval Date	 Effective	Date
Supersedes TN No.		HCFA ID:	7983E

Revision: HCFA- AUGUST	PM-91-4 1991	(BP)	D)	~	ATTACHMENT 2.2-A Page 7 OMB NO.: 0938-
Sta	te:	HAWAII	-		
Agency* Citati	on(s)		· · · · · ·	Groups Cove	red
	A. M. R	andatory equired	Coverage Special G	- Categorica roups (Contin	<u>lly Needy and Other</u> ued)
42 CFR 435.1	.34 2	for 92- in	the incr 336 (July August 19	ease in OASDI 1, 1972), wh	SSI/SSP eligible except benefits under Pub. L. o were entitled to OASD ere receiving cash
	•		for cash August 19	assistance bu	ould have been eligible t had not applied in p was included in this an).
	*	Ĥ	for cash medical i facility	assistance in natitution or	ould have been eligible August 1972 if not in a intermediate care as included in this an).
			care faci	cable with re lities; the S s service.	spect to intermediate tate did or does not

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

ATTACHMENT 2.2-A Page 8 OMB NO.: 0938-

HAWAII State:_

Agency* Citation(s)

Groups Covered

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

42 CFR 435.135

1

- 22. Individuals who --
 - 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 b. 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 receiving only SSP because the State eithe does not make such payments or does not provide Medicaid to SSP-only recipients.
 - \Box Not applicable because the State applies more restrictive eligibility requirements than those under SSI.
 - 11/ The State applies more restrictive 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 Date 10/01/91
Supersedes TN No. <u>87-17</u>		HCFA ID: 7983E

Revision:	HCFA-PM-91- August 1991	4 (BPD)	ATTACHMENT 2.2-A Page 9
	State:	HAWAII	OHB NO.: 0938-
Agency*	Citation(s)		Groups Covered
*	λ.	Mandatory Coverage - Required Special Gro	Categorically Needy and Other PUDE (Continued)
1634 Act	of the 1	eligible for S in their OASDI elimination of section 134 of for purposes of or SSP benefic	s and widowers who would be SI 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, of title XIX, to be SSI beneficiarie iaries for individuals who would be SP only, under section 1634(b) of
		receiving o does not ma	ble with respect to individuals only SSP because the State either the these payments or does not licaid to SSP-only recipients.
		standards t these indiv SSI Federal rate for in SSP only, w	pplies more restrictive eligibility than those under SSI and considers viduals to have income equalling the benefit rate, or the SSP benefit dividuals who would be eligible for then determining countable income for tegorically needy eligibility.

TN No. 91-21	Approval Date 10/13/92	Effective Date
Supersedes TN No. <u>89-7</u>		HCFA ID: 79838

Agency*	Citation(S)				Groups Covered
1634(d) Act	of the	۸.	Hand	atory o	Coverage - Categorically Needy and Other Social Groups (Continued)
	1	1		unmarn to the least effect are re of the elight in the began elight title	led widows, disabled widowers, and disal ried divorced spouses who had been marris insured individual for a period of at ten years before the divorce became tive, who have attained the age of 50, w beciving title II payments, and who because receipt of title II income lost which they for SSI or SSP which they receive 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, re 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>_X</u>	In determining eligibility as categorically needy, the State disregat the amount of the title II benefits identified in § 1634(d)(1)(A) in determining the income of the individu but does not disregard any more of the income than would reduce the individu income to the SSI income standard.
					In determining eligibility as categorically needy, the State disregation only part of the amount of the benefit identified in $(1)(1)(1)$ in determining the income of the individual which amount would not reduce the individual's income below the SSI incomestandard. The amount of these benefit to disregarded is specified in Supplet 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 individu

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

ATTACHMENT 2.2-A Page 9b

÷

Agency* Citation(s)	Groups Covered
	A. <u>Mandatory Coverage</u> - <u>Categorically Needy and Other</u> <u>Required Special Groups</u> (Continued)
	25. Qualified Medicare beneficiaries -
1902(a)(10)(E)(i), 1905(p) and	a. Who are entitled to hospital insurance benefits under Medicare Part A, (but not pursuant to an enrollment under section 1818A of the Act);
1860D-14(a)(3)(D) of the Act	b. Whose income does not exceed 100 percent of the Federal poverty Level; and
	c. Whose resources do not exceed three times the SSI resource limit, adjusted annually by the increase in the consumer price index.
	(Medical assistance for this group is limited to Medicare cost-sharing as defined in item 3.2 of plan)
	26. Qualified disabled and working individuals
1902(a)(10)(E)(ii) and 1905(s) of the Act	 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 two times the SSI resource limit.
	 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 the Act.)

*Agency that determines eligibility for coverage.

.

.

,

,

.

.

ł

TN No. Supersedes	10-001	Approval Date:	MAY 2 8 2010	Effective Date: 01/01/10
TN No.	<u>93-03</u>	· •		

ATTACHMENT 2.2-A Page 9b1

	State:Hawaii
Agency* Citation(s)	Groups Covered
	A. <u>Mandatory Coverage</u> - <u>Categorically Needy and Other</u> <u>Required Special Groups</u> (Continued)
	27. Specified low-income Medicare beneficiaries
1902(a)(10)(E)(iii), 1905(p)(3)(A)(ii), and	 a. Who are entitled to hospital insurance benefits under Medicare Part A (but not pursuant to an enrollment under section 1818A of the Act);
1860D-14(a)(3)(D) of the Act	 Whose income is greater than 100 percent but less than 120 percent of the Federal poverty level; and
	c. Whose resources do not exceed three times the SSI resource limit, adjusted annually by the increase in the consumer price index.
	(Medical assistance for this group is limited to Medicare Part B premiums under section 1839 of the Act.)
1902(a)(10)(E)(iv)	28. Qualifying Individuals
and 1905(p)(3)(A)(ii) and 1860D-14(a)(3)(D) of the Act	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 is at least 120 percent but less than 135 percent of the Federal poverty level;
	c. Whose resources do not exceed three times the SSI resource limit, adjusted annually by the increase in the consumer price index.

ATTACHMENT 2.2-A Page 9b2

.

		State:			Hawaii
Agency*	Citation(s)	[_]			Groups Covered
		A			tory Coverage - Categorically Needy and Other ed Special Groups (Continued)
1634(e)	of the Act		29.	а.	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.
			<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 clauses (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.

.

.

.

Revision:	HCFA-PM-91- AUGUST 1991	4 (BPD)	ATTACHMENT 2.2-A Page 9c
	State:	HAWAII	OMB No.: 0938-
gency*	Citation(s)	Groups Covered	
	8.	Optional Groups Other Than the	e Medically Needy
43: 19 (10	CFR <u>/X</u> / 5.210 02(a) 0)(A)(11) and 05(a) of a Act	1. Individuals described below income and resource require optional State supplement a CFR 435.230, but who do not assistance.	ements of AFDC, SSI, or an as specified in 42
	١	The plan covers all above.	individuals as described
5- 17		$\frac{1}{1}$ The plan covers only group or groups of in	the following ndividuals:
		X Aged X Blind X Disabled X Caretaker relative X Pregnant women	
	CFR <u>/</u> 5.211	2. Individuals who would be el or an optional State supple CFR 435.230, if they were r institution.	ement as specified in 42

TN No. <u>91-21.</u> Supersedes	Approval Date 10/13/92	Effective Date 10/01/91
TN No. <u>89.07</u>	-	HCFA ID: 7983E

Revision: HCFA-PM-91-10 December 1991

(BPD)

ATTACHMENT 2.2-A Page 10

Decemb	er 1991		Page 10
	State:	HAWAII	-
Agency*	Citation(s)	Groups Covered	
Agency* 12 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> (Co	ional Groups Other Than the Med ntinued) The State deems as eligible those became otherwise ineligible for enrolled in an HMO qualified un Public Health Service Act, or a is organization (MCO), or a prima management (PCCM) program, enrolled in the entity for less that enrollment period listed below. section is limited to MCO or PC family planning services descrit 1905(a)(4)(C) of the Act. The State elects not to guarantee The State elects to guarantee eliminimum enrollment period is exceed six).	ically Needy e individuals who Medicaid while nder Title XIII of the managed care ry care case but who have been in the minimum Coverage under this CCM services and bed in section e eligibility. gibility. The months (not to
		The State measures the minimum from: [] The date beginning the enrollment in the MCC any intervening disense Medicaid eligibility.	period of or PCCM, without
		[] The date beginning the enrollment in the MCC Medicaid patient (inclu payment is made under any intervening disence) or PCCM as a ading periods when this section), without
Agency that determin		[] The date beginning the enrollment in the MCC Medicaid patient (not in payment is made under any intervening disence enrollment as a private new minimum enrollment time the individual bec eligible other than under	or PCCM as a ncluding periods when this section) without ollment or periods of ly paying patient. (A ent period begins eac omes Medicaid

TN No.	03-003		-0		AUG 13
Supersedes TN No.	1. 97-21	Approval Date:	MAR ·	2 2004 Effective Date:	

Revision:	HCFA-PM- December		(BPD)	ATTACHMENT 2.2 Page 10a
		State:	HAWAII	
Agency*	Ci	tation(s)	Groups Cove	ered
1932(a)(4)	of the Act	B.	Optional Groups Other Than the (Continued)	e Medically Needy
			The Medicaid Agency may elect disenrollment of Medicaid enrol PAHPs, and PCCMs in accordan 42 CFR 438.56. This requirement recipient can demonstrate good he/she moves out of the entity's ineligible.	llees of MCOs, PIHPs, nce with the regulations at ent applies unless a cause for disenrolling or if
			X Disenrollment rights are	restricted for a not to exceed 12 months).
			During the first three mo period the recipient may The State will provide no per year, to recipients en organization of their righ terminating such enrollm	disenroll without cause. otification, at least once rolled with such at to and restrictions of
		_	No restrictions upon dise	nrollment rights.
903(m)(2)(1 902(a)(52) Act P.L. 101-508 2 CFR 438.	of the	l 1 H N	n the case of individuals who have Medicaid for the brief period des 903(m)(2)(H) and who sere enr PIHP, PAHP, or PCCM when the Medicaid agency may elect to re he same entity if that entity still	scribed in section olled with an MCO, ey became ineligible, the enroll those individuals in
		2	The agency elects to provi reenrollment of the above entity if they were disenro loss of Medicaid eligibility or less.	individuals into the same lled solely because of
Agency that	determines	eligibilit	The agency elects not to re into the same entity in whi enrolled. y for coverage.	
N No. 03	3-003	•	MAR 2 2004	

C

Revision:	HCFA- August	PM-91-1-4 1991	(BPD)	ATTACHMENT 2.2-A Page 11 OMB NO.: 0938 -
		State:	НАЖАП	
Agency	*	Citation(s)	Groups Cover	ed
		B.	Optional Groups Other Than the Me (Continued)	dically Needy
42 CFR 43	35.217 [X	4. A group or groups of individue of the eligible for Medicaid unwere in a NF or an ICF/M provision of home and conunder a waiver granted unsubpart G would require inwho will receive home and services under the waiver. covered are listed in the wave option is effective on the estate's section 1915(c) was group(s) is covered. In the 1915(c) waiver is amendment	nder the plan if they R, who but for the nmunity-based services der 42 CFR Part 441, institutionalization, and d community-based The group or groups aiver request. This effective date of the iver under which this e event an existing d to cover this group(s),

amendment.

HCFA-PM-91-4 AUCUST 1991 State:	(BPD) Hawaii	ATTACHMENT 2.2-A Page 11a OMB NO.: 0938-
itation(8)		Groups Covered
		ips Other Than the Medically Needy
(VII)	Medicald u medical in ill, and w accordance	is who would be eligible for inder the plan if they were in a istitution, who are terminally who receive hospice care in with a voluntary election described in 005(0) of the Act.
		The State covers all individuels as described above.
		The State covers only the following group or groups of individuals:
		Aged Disabled Individuals under the age of 21 20 19 18
	(C	(Continued) (10) <u>X7</u> 5. Individual (VII) Medicaid u Medicaid u medical in ill, and v accordance section 15 <u>X7</u> 1 C7

Pregnant women

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

Revision:	HCFA-PM-91 AUGUST 1991		(BPD)		ATTACHMENT 2.2-A Page 15 OMB NO.1 0938-
	State: _		HAWAII		
Agency*	Citation(s)				Groups Covered
		B.	Optional (Continue		s Other Than the Medically Needy
42 CFF	435.230	D	10. <u>St.</u>	ates u	sing SSI criteria with agreements under 1616 and 1634 of the Act.
			on pa su	ly a S yment) ppleme	owing groups of individuals who receive tate supplementary payment (but no SSI under an approved optional State ntary payment program that meets the g conditions. The supplement is
			۵.	Based basis	on need and paid in cash on a regular
			Ъ.	indiv	to the difference between the idual's countable income and the income ard used to determine eligibility for upplement.
			с.	Avail	able to all individuals in the State.
			d.	. of in eligi	to one or more of the classifications dividuals listed below, who would be ble for SSI except for the level of income.
				(1)	All aged individuals.
				(2)	All blind individuals.
				(3)	All disabled individuals.

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

Revision:	HCFA-PM-91-4 AUGUST 1991			ATTACHMENT 2.2-A Page 16 Omb No.: 0938-
	State:	HAWAII		
Agency*	Citation(s)			Groups Covered
		B. <u>Optional</u> (Continu		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)	
	· · ·		(6)	Disabled individuals in domiciliary facilities or other group living arrangements as defined under SSI.
			(7)	Individuals receiving a Federally administered optional State supplemen that meets the conditions specified i 42 CFR 435.230.
		_	(8)	Individuals receiving a State administered optional State supplemen that meets the conditions specified i 42 CFR 435.230.
			(9)	Individuals in additional classifications approved by the Secretary as follows:

Ć,

2.

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

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

1

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

State: HAWAII

Agency* Citation(s)

Groups Covered

B. Optional Groups Other Than the Medically Needy (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

Revision:	HCFA-PM-91- AUGUST 1991	4 (B	IPD)	ATTACHMENT 2.2-A Page 17
	State:	HAWA	11	OMB NO.: 0938-
Agency*	Citation(s)			Groups Covered
	,	B. <u>Opti</u> (Con	onal Gro tinued)	oups Other Than the Medically Needy
and 4 1902 (35.230 a) (10) (A) _	<u>/x</u> / 11.		1902(f) States and SSI criteria States agreements under section 1616 or 1634
(ii) () ACt	XI) of the	•.	a State options that me	lowing groups of individuals who receive supplementary payment under an approve 1 State supplementary payment program ets the following conditions. The sent is
		Ē.	a. Base basi	d on need and paid in cash on a regular s.
			indi stan	I to the difference between the vidual's countable income and the incom dard used to determine eligibility for supplement.
			c. Avai clas basi	lable to all individuals in each sification and available on a Statewide S.
				to one or more of the classifications ndividuals listed below:
			_ (1)	All aged individuals.
			_ (2)	All blind individuals.
			_ (3)	All disabled individuals.

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

Revision:	HCFA-PM-91-4 AUGUST 1991 State:	(BPD) HAWAII		ATTACHMENT 2.2-A Page 18 OMB NO.: 0938-		
Agency*	Citation(s)	-	Groups Covered			
	В.	 Optional Groups Other Than the Medically Need (Continued) 				
		*	(4)	Aged individuals in domiciliary facilities or other group living arrangements as defined under SSI.		
	•	<u> </u>	(5)	Blind individuals in domiciliary facilities or other group living arrangements as defined under SSI.		
1		<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
TN No. 87-16		HCFA ID: 7983E

	Revision:	HCFA-PM-91-4 August 1991 State:	(BPD) Hawaii	ATTACHMENT 2.2-A Page 18a OMB NO.: 0938-	
	Agency*	Citation(s)		Groups Covered	
			. <u>Optional Groups Ot</u> (Continued)	her Than the Medically Needy	
•			The supplement political subc cost-of-living	t varies in income standard by divisions according to g differences.	

Yes

No

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

	Approval D	ate 10/13/92	Effective Date 10/01/91
TN No.			UCPL TD. 1983P

١

Revision:	HCFA-PM-91-4 August 1991	(BPD)	ATTACHMEN. 2.2-A Page 19		
	State:	HAWAII	OMB No.: 0938-		
Agency*	Agency* Citation(s)		Groups Covered		
	в.	Optional (Continue	Groups Other Than the Medically Needy d)		
42 CFF 1902(4 (A)(1) of the	L)(V)	leas elig Elig the meet	viduals who are in institutions for at t 30 consecutive days and who are ible under a special income level. ibility begins on the first day of 30-day period. These individuals the income standards specified in lement 1 to <u>ATTACHMENT 2.6-A</u> .		
		LT The abov	State covers all individuals as described e.		
·		The grou	State covers only the following group or ps of individuals:		
	a)(10)(A) and 1905(a) a Act	Ξ	Aged Blind Disabled Individuals under the age of 21 20 19 18 Caretaker relatives		

TN No. <u>91-21</u> Supersedes		
Supersedes TN No. 89-3	Approval Date 10/13/92	Effective Date 10/01/91
IN NO. 03-5	•	HCFA ID: 7983E

Revision:	HCFA-P	N-91-4 1991	(BP	PD) ATTACHMENT 2.2-A Page 20
	Stat	•:	HAWA	ONB NO.: 0938-
Agency*	Citatio	n(s)		Groups Covered
Í., .		в.		nal Groups Other Than the Medically Needy
1902(of the			13.	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 Ac
			•	Supplement 3 to ATTACHMENT 7.2-A describes the method that is used to determine the cost effectiveness of caring for this group of disabled children at home.
(A) (1:	a)(10) i)(IX) 902(1) e Act	£₹/	14.	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 <u>ATTACHMENT 2.6-A</u> for a family of the same size, including the woman and unborn child or infant and who meet the resource standards specified in <u>Supplement 2 to ATTACHMENT 2.6-A</u>
			۵.	Women during pregnancy (and during the 60-day period beginning on the last day of pregnancy); and
			Þ.	Infants under one year of age.

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

.

•

Revision:	HCFA-PM-91-4 AUGUST 1991 State:	4 (BPC Hawaii)	ATTACHMENT 2.2-A Page 22 OMB NO.: 0938-
Agency*	Citation(s)		Gz	oups Covered
	E	B. <u>Optiona</u> (Contin		er Than the Medically Needy
1902(4 (ii)() and 15 (1) ar of the	())02(m)	a. H _ a _ 8 B	re disabled, ection 1614(oth aged and	ears of age or older or as determined under a)(3) of the Act. i disabled individuals are covered igibility group.
		(t	established	does not exceed the income level at an amount up to 100 percent of ncome poverty level) specified in to <u>ATTACHMENT 2.6-A</u> for a family ize; and
		a	mount allowe ore restrict he State's m	es do not exceed the maximum d under SSI; under the State's live financial criteria; or under edically needy program as <u>ATTACHMENT 2.6-A</u> .
	1			

TN No. <u>91-21</u> Supersedes	Approval Date 10/	13/92 Effective	Date 10/01/91
TN No. <u>88.38</u>		HCFA ID:	7983E

Revision: HCFA-PM-91-8 October 1991

."

(MB)

ATTACHMENT 2.2-A Page 23a OMB NO.:

-

	State/Territo	ory:	НАЖАП
Citation		Grou	ps Covered
	B.		overage Other Than the Medically Needy ntinued)
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.
902(a)(10)(F) nd 1902(u)(1) of the Act		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 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 Supplement 11 to Attachment 2.6-A.

JUL 1 2001

ATTACHMENT 2.2-A Page 23c

-

State:		НАЖАП
		The following reasonable classifications of children described above who are under age(18, 19) 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.)
1902(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.
920A		
1 902A of the Act	22.	Children under age 19 who are determined by a "qualified 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 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.

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

• •

Approval Date: OCT 1 8 2001 Effective Date:

1 2001 JUL

ATTACHMENT 2.2-A Page 23d

	State:	H	AWAII
Citation(s)			Groups Covered
		В.	Optional Coverage Other Than the Medically Needy (Continued)
1902(a)(10)(A) and 1920 of the Act		<u>X</u> 23.	Women who:
		a.	have been screened for breast or cervical cancer under the Centers for Disease Contr and Prevention Breast and Cervical Cancer Early Detection Program established under
			title XV of the Public Health Service Act in accordance with the requirements of section 1504 of that Act and need treatment for breast or cervical cancer, including a pre- cancerous condition of the breast or cervix:
	*	b.	are not otherwise covered under creditable coverage, as defined in section 2701 (c) of the Public Health Service Act;
		c.	are not eligible for Medicaid under any mandatory categorically needy eligibility group; and
		d.	have not attained age 65.
920B of the Act		informatio	Women who are determined by a "qualified s defined in 1920B (b) based on preliminary on, to be a woman described in 1902 (aa) of the d to certain breast and cervical cancer patients.
		determina the State woman's apply for made on l	imptive period begins on the day that the ation is made. The period ends on the date that makes a determination with respect to the eligibility for Medicaid, or if the woman does n Medicaid (or a Medicaid application was not her behalf) by the last day of the month followin in which the determination of presumptive
			was made, the presumptive period ends on that
N No. 01-006		. OCT 18	2001 Effective Date: JUL 1 2001

Supersedes TN No.

Effective Date:

	HCFA-PM-91- August 1991	.4 (BPD)	ATTACHMENT 2.2-A Page 24
	State: _	HAWAII	OKŠ NO.: 0938-
Agency* C	itation(s)		Groups Covered
	с.	Optional Coverage of	the Medically Needy
42 CFR	435.301	This plan includes th	ne medically needy.
		<u>_7</u> No.	
	1	\underline{X} Yes. This plan	COVETS:
		1. Pregnant women who resources, would b under title XIX of	b, except for income and/or be eligible as categorically needy I the Act.
1902(e) Act	of the	for and have apply receive Medicaid a the approved State ends. These women they were pregnant postpartum service period, beginning	pregnant, were eligible led for Medicaid and as medically needy under plan on the date the pregnancy a continue to be eligible, as thou t, for all pregnancy-related and as under the plan for a 60-day with the date the pregnancy ends, days in the month in which the 60
1902(a) (C)(11) of the	(I)	3. Individuals under income and/or reso under section 1902	age 18 who, but for burces, would be eligible R(a)(10)(A)(i) of the Act.

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

	AUGUST 1991 State:	(BPD) Hawaii	ATTACHMENT 2.2-A Page 25 OMB NO.: 0938-
Agency* C	itation(s)		Groups Covered
<u></u>	c. g	Optional Coverag	e of Medically Needy (Continued)
1902(e) the Act	(4) of 4	October 1, 19 as medically Medicaid on t is deemed to Medicaid on t for one year	Fren born on or after 184 to a woman who is eligible needy and is receiving the date of the child's birth. The child have applied and been found eligible for the date of birth and remains eligible so long as the woman remains eligible I is a member of the woman's household.
42 CFR 4	135.308 5	descrit under t	ally eligible individuals who are not bed in section C.3. above and who are the age of 1 0 9 8 or under age 19 who are full-time. Students in a secondary school or in the oquivalent level of vocational or sechnical training
	L	eligibl	ble classifications of financially le individuals under the ages of 21, 20, 18 as specified below:
			Individuals for whom public agencies are assuming full or pertial financial responsibility and who are:
		<u>x</u> (a)	In foster homes (and are under the age of 21).
		<u>X</u> (Þ)	In private institutions (and are under the age of 21).
MM No. 91	- 21		

(

.

	Approval Date	10/13/92	Effective Date 10/01/91
TN No.			UCT1 TD. 74817

Revision:	HCFA-PM-91-4 August 1991	(BPD)	ATTACHMENT 2.2-A Page 25a
State:	State:	HAWAII	OMB NO.: 0938-
Agency*	Citation(S)		Groups Covered
	c. g	ptional Cove	rage of Medically Needy (Continued)
	1	<u> </u>	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>x</u> (2)	Individuals in adoptions subsidized in full or part by a public agency (who are under the age of 21).
		<u>x</u> (3)	Individuals in NFs (who are under the age of 19). NF services are provided under this plan.
		<u>x</u> (4)	In addition to the group under (b)(3), individuals in ICFs/MR (who are under the age of <u>19</u>).
		<u>x</u> (5)	Individuals receiving active treatment as inpatients in psychiatric facilities or programs (who are under the age of 19). Inpatient psychiatric services for individuals under age 21 are provided under this plan.
		<u>X</u> (6)	Other defined groups (and ages), as specified in Supplement 1 of ATTACHMENT $2, 2-\lambda$.

•

TN No. 91-21 Supersedes TN No. 90-1	Approval	Date	10/13/92	Effective Date 10/01/91
TH 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.		tiona ontin	l Coverage of Medically Needy ued)			
42 C.F.R. 435.	310			6.	Caretaker relatives			
42 C.F.R. 435.	320 and 435.330			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:			
					 Meet all current requirement for Medicaid eligibility except the blindness or disability criteria; 			
42 C.F.R. 435.	326				 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
 Approval Date:
 09/30/2013
 Effective Date:
 01/01/2014

 TN No.
 91-21
 Output
 Output

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

1935(a) and 190)2(a)(66)	The agency provides for making Medicare prescription
42 CER 423 7		drug Low Income Subsidy determinations under Section
42 CFR 423.774 and 423.904		1935(a) of the Social Security Act.
and 423.904		1. 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;
		2. 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.
		1905(p)(3) of the Act and offering enrollment to eligible individuals under the State plan or under a

Approval Date: SEP 0 2 2005Effective Date:

07/01/05

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Hawaii

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					

Revision: HCFA-PM-87-4 (BERC) MARCH 1987 SUPPLEMENT 2 TO ATTACHMENT 2.2-A Page 1 OMB No.: 0938-0193

56 .

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

RECEIVER State: HAWATI

A. DEFINITION OF BLINDNESS IN TERMS OF OPHTHALNIC MEASUREMENT

- -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 subtends an angular-distance no--

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

Not applicable.

*Agency that determines eligibility for coverage.

TN No. 87-11 Approval Date NOV 17 1987 **Effective Date** Supersedes TN NO. A 10 HCFA ID: 2002P/0021P

1.00

í

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

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: <u>HAWAII</u>

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

Not Applicable

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

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

ATTACHMENT 2.6-A Page 1

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: HAWAII

BLIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)

Condition or Requirement

A. General Conditions of Bligibility

Each individual covered under the plans

42 CFR Part 435, Subpart G

42 CFR Part 435, Subpart F

- 1. Is financially eligible (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 AFDC-related individuals, meets the non-financial eligibility conditions of the AFDC program.
 - (11) 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.

TN NO. 92-15 Supersedes Approval Date 10/29/92 Effective Date 7/1/92 91-21 TH NO.



:

i 1

•

.

:

I.

1902(1) of the Act

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 Part 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 nonimmigrants 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. Elected for children under age 19 X 42 CFR 435.406 1902 (b) 4. Is a resident of the State, regardless whether or not the individual maintains the residence of the Act permanently or maintains it at a fixed address. State has interstate residency agreement with the following States: State has open agreement(s). 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: HAWAII

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement			
2 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.			
2 C.F.R. 435.1008 905(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 1903(v)(2) of the Social Security Act			
	(Section 1137(f)).			

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

Revision:	HCFA-PM October 19		(BPD)			ATTACHMI Page 3c OMB NO.:	ENT 2.6- 0938 -
•		State:		HAWAII			
Citatic	Citation Citation: 10. 906 of the Act J.S. Supreme X 11.			Condition or	Requiremen	nt	
Citation:		10.	Conflict of	Interest Provision	ons		
,	-			-1.76°			hand
1900 OI INC	ACI		cost-effectiv	to apply for enrove group health	plan, if suc	h plan is ava	ailable
	* *			dual. Enrollme		-	
			•	ne individual wi (failure of a par			
				d's eligibility).			
U.S. Supren	ne	X 11.	Is required t	o apply for cov	erage unde	r Medicare I	Parts A,
Court case I	Vew		-	if it is likely th			
York State Department	of .		-	y criteria for an rees to pay any	-		
Social Servi	-			ept those appli	**		
v. Dublino,4				required to appl		* *	
U. S. 405 (1	973)			e is a condition the Medicare			
				xcept those app			
			persons cov	ered by the Me	dicaid eligi		
			which the in	dividual is app	lying.		

TN No. Supersedes TN No. 05-008

(

Approval Date: MOV 1 8 2005 Effective Date:

01/01/06

Revision: HCFA-PM-97-2 December 1997 ATTACHMENT 2.6-A Page 4 OMB No.:0938-0673 State: HAWAII OMB No.:0938-0673 Citation Condition or Requirement B. Posteligibility Treatment of Institutionalized Individuals' Incomes 1. The following items are not considered in the posteligibility process:

1

1902(o) of the Act

Bondi v

Sullivan (SSI)

1902(r)(1) of

P. L. 100-383

P.L. 103-286

P.L. 101-239

105/206 of

1. (a) of

10405 of

6(h)(2) of .

12005 of

P. L. 103-66

P.L. 101-426

the Act

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.

b. 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.

c. German Reparations Payments (reparation payments made by the Federal Republic of Germany).

- d. Japanese and Aleutian Restitution Payments.
- e. Netherlands Reparation Payments based on Nazi, but not Japanese, persecution (during World War II).
- 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.)
- g. Radiation Exposure Compensation.
- h. VA pensions limited to \$90 per month under 38 U.S.C. 5503.

TN No. 98-003 Supersedes		
Supersedes	Approval Date 12/11 99	Effective Date_101198
TN No. 91-21		

Revision: CMS-PM 97-2 May 2002

. 1

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

Citation	Condition or Requirement						
1924 of the Act 435.725 435.733 435.832	2. The following monthly amounts for personal needs are deducted from total monthly income in the application of an institutionalized individual's or couple's income to the cost of institutionalized care:						
	Personal Needs Allowance (PNA) of not less than \$50 for Individuals and \$100 for Couples for all Institutionalized Persons.						
	a. Aged, blind, disabled:						
	Individuals <u>\$ 50.00</u> Couples <u>\$100.00</u>						
	For the following persons with greater need:						
	Supplement 12a to <u>Attachment 2.6-A</u> 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						
	b. AFDC related:						
	Children \$ 50.00 Adults \$ 50.00						
	For the following persons with greater need:						
	Supplement 12a to <u>Attachment 2.6-A</u> 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 						

Approval Date: DEC 1 2 2007, Effective Date:

07/01/07

 TN No.
 07-006

 Supersedes
 98-003

O C .		HCFA-PM-97- December 199	
	State:	HAWAII	
	Citation	n	Condition or Requirement
			For the following persons with greater need:
		sla	Supplement 12 to <u>Attachment 2.6-A</u> describes the preater need; describes the basis or formula for letermining the deductible amount when a specific amount is not listed above; lists the criteria to be met; and, where appropriate, identifies the brganizational unit which determines that a criterion is met.
	1924 of the Ac		n addition to the amounts under item 2., the following monthly mounts are deducted from the remaining income of an institutionalized individual with a community spouse:
\circ			The monthly income allowance for the community spouse, calculated using the formula in $\$1924(d)(2)$, is the amount by which the maintenance needs standard exceeds the community spouse's income. The maintenance needs standard cannot exceed the maximum prescribed in $\$1924(d)(3)(C)$. The maintenance needs standard consists of a poverty level component plus an excess shelter allowance.
		, <i>*</i>	The poverty level component is calculated using the applicable percentage (set out §1924(d)(3)(B) of the Act) of the official poverty level.
			The poverty level component is calculated using a percentage greater than the applicable percentage, equal to %, of the official poverty level (still subject to maximum maintenance needs standard).
			X The maintenance needs standard for all community spouses is set at the maximum permitted by $\S1924(d)(3)(C)$.
			Except that, when applicable, the State will set the community spouse's monthly income allowance at the amount by which exceptional maintenance needs, established at a fair hearing, exceed the community spouse's income, or at the amount of any court- ordered support.
ÖL	TN No. 98-00 Supersedes TN No.)3 Apj	roval Date 12/11/98 Effective Date 10/11/98

Revision: HCFA-PM-97-2 ATTACHMENT 2.6-A December 1997 Page 4c OMB No.:0938-0673 HAWAII State: Citation Condition or Requirement In determining any excess shelter allowance, utility expenses are calculated using: 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. b. The monthly income allowance for other dependent. family members living with the community spouse is: 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 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 law but not covered under the State plan. (Reasonable limits on amounts are described in Supplement 3 to <u>ATTACHMENT 2.6-A.</u>)

TN No.	98-003
Supersec	6
TN No.	

Approval Date 12/11/98

Effective Date 10 1 94

Revision:	HCFA-PM-9 December	7-2 1997	ATTACHMENT 2.6-A Page 5
Sta	te: <u>HAWAII</u>		OMB No.:0938-0673
Citation		Condition	n or Requirement
435.725 435.733 435.832	4.	above, the following mo	nts deductible under the items onthly amounts are deducted from ncome of an institutionalized onalized couple:
	a.	tamily living in the institution of community spouse liv	tenance needs of each member of a utionalized individual's home with ving in the home. The amount must be assessment of need but must not exceed
		o AFDC level; or o Medically needy leve	ə l.
<u>.</u>		(Check one)	
		- AFDC levels in Su X Medically needy le - Other: S	evel in Supplement 1
		deducted under 3.c. above community spouse), are in	e expenses described below that have not be ve (i.e., for an institutionalized individual with curred by and for the institutionalized individu e, and are not subject to the payment by a thir
			e, and other health insurance premium urance charges, or copayments.
		not covered under the	r remedial care recognized under State law bu e State plan. (Reasonable limits on amount an ent 3 to <u>ATTACHMENT 2.6-A.)</u>
435.725 435.733 435.832	5.	At the option of the State is deducted from any ren institutionalized individu	a, as specified below, the following naining monthly income of an al or an institutionalized couple:
	Ап	ple for not longer than	maintenance of the home of the individual of 6 months if a physician has certified that the 5 the institutionalized couple, is likely to return
	indi	he home within that perio	d:
	indiv to the	he home within that perio	d:
	indiv to the	he home within that perio	d: e amount is shown on page 5a.)

Revision: HCFA-PM-97-2 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 §1924 (d)(1) of the Act.

Approval Date 12/11/28

TN No	<u>98-003</u>
Supers	edes 94-002
TN No	94-002

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: Hawaii

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement			
42 C.F.R. 435.601,435.631, 435.831	C. Financial Eligibility			
£22.02T	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			
	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				
Supersedes	6 ² 0 ²	Approval Date:	02/12/2014	Effective Date:	10/01/2013
TN NO.	92-15		9		

Supersedes

TN No.

92-15

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 tha 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-PH-92-1 (MB) FEBRUARY 1992

1902(e)(6) the Act

C

1

1

1. 1.

ť

ATTACHMENT 2.6-1 Page 7

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

States	HA	WAII			
······································	BLIGIBIL	ITY CONDI	TIONS	AND	REQUIREMENTS
Citation(s)		Cond	ition	or R	equirement
1902(r)(2) of the Act	1.		1		ning Income
		leve	dren)	ated	ndividuals (except for poverty pregnant women, infants, and
. · ·		(1)	AFDC	-rela	ining countable income for ted individuals, the following re used:
			<u>_X</u> _	(2)	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)	resp the hous inco	incon incon schold me of	aining relative financial bility, the agency considers on the of spouses living in the same as available to spouses and the f parents as available to child th parents until the children

become 21.

(3) Agency continues to treat women eligible under the provisions of sections 1902(a)(10) of the Act as eligible, witho regard to any changes in income of the family of which she is a member, for the 60-day period after her pregnancy ends an any remaining days in the month in which 60th day falls.

() TN No. <u>92-15</u> Supersedes TN No. <u>91-21</u> Approval Date <u>10/29/92</u> Effective Date 7/1/92

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

ATTACHMENT 2.6-A Page 74

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: HAWAII

BLIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)Condition or Requirement42 CFR 435.721b. 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 Act0f the Act1902(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 <u>Suppleme</u> Ba to ATTACHMENT 2.6-A.



2

1:

07

1

1

1

Supersedes	72-13	Approval	Date	10/29/92
TN NO.	91-21			

DY_TE

State:	<pre>supplement recipients, more restrictive methods than SSI, applied under the provisions of section 1902(f) of the Act, as specified in <u>Supplement 4 to ATTACHMENT 2.6-A;</u> and any more liberal methods described in <u>Supplement 8a to ATTACHMENT 2.6-A</u>. For institutional couples, the methods specified under section 1611(e)(5) of the Act. For optional State supplement recipients under \$435.230, income methods more liberal than SSI, a specified in <u>Supplement 4 to ATTACHMENT 2.6-A</u>. For optional State supplement recipients in</pre>
	For individuals other than optional State supplement recipients, more restrictive methods than SSI, applied under the provisions of section 1902(f) of the Act, as specified in <u>Supplement 4</u> to <u>ATTACHMENT 2.6-A</u> ; and any more liberal methods described in <u>Supplement 8a to ATTACHMENT 2.6-A</u> . For institutional couples, the methods specified under section 1611(e)(5) of the Act. For optional State supplement recipients under \$435.230, income methods more liberal than SSI, a specified in <u>Supplement 4 to ATTACHMENT 2.6-A</u> . For optional State supplement recipients in
	<pre>supplement recipients, more restrictive methods than SSI, applied under the provisions of section 1902(f) of the Act, as specified in <u>Supplement 4 to ATTACHMENT 2.6-A;</u> and any more liberal methods described in <u>Supplement 8a to ATTACHMENT 2.6-A</u>. For institutional couples, the methods specified under section 1611(e)(5) of the Act. For optional State supplement recipients under \$435.230, income methods more liberal than SSI, a specified in <u>Supplement 4 to ATTACHMENT 2.6-A</u>. For optional State supplement recipients in</pre>
	under section 1611(e)(5) of the Act. For optional State supplement recipients under \$435.230, income methods more liberal than SSI, a specified in <u>Supplement 4 to ATTACHMENT 2.6-A</u> . For optional State supplement recipients in
	<pre>\$435.230, income methods more liberal than SSI, a specified in <u>Supplement 4 to ATTACHMENT 2.6-A</u>. For optional State supplement recipients in</pre>
<u>/x</u> /	
	section 1902(f) States and SSI criteria States without section 1616 or 1634 agreements
2	X SSI methods.anlar
	SSI methods and/or any more liberal methods than SSI described in <u>Supplement Sa to</u> <u>ATTACHMENT 2.6-A</u> .
	X Methods more restrictive and/or more liberathan 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 8a to ATTACHMENT 2.6-A</u> .
	In determining relative financial responsibility, the agency considers only the income of spouses living in the same household as available to spouses.

TH No.

HCFA ID: 7985E

...

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

URWRTT

State		HAWAII					
Citation			Condition or Requirement				
2 CFR 435.721 35.831 902(m)(1)(B), m)(4), and 902(r)(2) of he Act	and	income methods <u>X</u> T	ndividuals. In determining countable for blind individuals, the following are used: he methods of the SSI program. GREYX SI methods and/or any more liberal methods				
•			escribed in <u>Supplement 8a to ATTACHMENT</u>				
	1	50 00 <u>5</u> 1	or individuals other than optional State upplement recipients, more restrictive sthods than SSI, applied under the provisions f section 1902(f) of the Act, as specified in upplement 4 to ATTACHMENT 2.5-A, and any more iberal methods described in <u>Supplement 8a to</u> TTACHMENT 2.5-A.				
			or institutional couples, the methods pecified under section 1611(e)(5) of the Act.				
		S	or optional State supplement recipients under 435.230, income methods more liberal than SSI s specified in <u>Supplement 4 to ATTACHMENT</u> .6-A.				
		8	or optional State supplement recipients in action 1902(f) States and SSI criteria States ithout section 1616 or 1634 agreements				
		×	SSI methods. salyr				
			SSI methods and/or any more liberal methods than SSI described in <u>Supplement & to</u> <u>ATTACHMENT 2.6-A</u> .				
		<u>_X</u> _	Methods more restrictive and/ or more liberal than SSI. More restrictive methods are described in <u>Supplement 4 to ATTACHMENT</u> <u>2.6-A</u> and more liberal methods are described in <u>Supplement Sa to ATTACHMENT 2.6-A</u> .				

HCFA ID: 7985E

Revision: HCFA-PM-91-4 (BPD) ATTACHMENT 2.6-A AUGUST 1991 Page 10 OHB No.: 0938-HAWAII State:__ Citation Condition or Requirement In determining relative responsibility, the agency considers only the income of spouses living in the same household as available to spouses and the income of parents as available to children living with parents until the children become 21. 42 CFR 435.721, d. Disabled individuals. In determining countable income of disabled and 435.831 1 individuals, including individuals with incomes up to the Federal poverty 1902(m)(1)(B), (m)(4), and level described in section 1902(m) of 1902(r)(2) of the Act the following methods are used: the Act X The methods of the SSI.program SSI methods and/or any more liberal methods described in Supplement Sa to ATTACHMENT 2.6-1. For institutional couples: the methods specified under section 1611(e)(5) of the Act. For optional State supplement recipients under \$435.230: income methods more liberal than SSI, as specified in <u>Supplement 4 to ATTACHMENT</u> 2.6-1. <u>X</u> For individuals other than optional State supplement recipients (except aged and disabled individuals described in section 1903(m)(1) of the Act): more restrictive methods than SSI, applied under the provisions of section 1902(f) of the Act, as specified in Supplement 4 to ATTACHMENT 2.6-A; and any more liberal methods described in Supplement is to ATTACHMENT 2.6-A.

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

Revision:	HCFA-PM-91-4 August 1991	(BPD)	ATTACHMENT 2.6-A Page 11
	State:	HAWA	OMB No.: 0938-
Citati	on		Condition or Requirement
		39	r optional State supplement recipients in ction 1902(f) States and SSI criteria States thout section 1616 or 1634 agreements
		<u>_x</u>	SSI methods. mig
			SSI methods and/or any more liberal methods than SSI described in <u>Supplement Ba to</u> <u>ATTACHMENT 2.5-A</u> .
	1	<u>_x</u> _	Methods more restrictive and/or more liberal than SSI, except for aged and disabled individuals described in section $1902(m)(1)$ of the Act. More restrictive methods are described in <u>Supplement 4 to ATTACHMENT</u> <u>2.6-A</u> and more liberal methods are specified in <u>Supplement 8a to ATTACHMENT 2.6-A</u> .
		agency of the same income of	mining relative financial responsibility, the onsiders only the income of spouses living in household as available to spouses and the f parents as available to children living ents until the children become 21.

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

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

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

In determining relative financial (2) responsibility, the agency considers only the income of spouses living in the same household as available to spouses and the ----income of parents as available to children living with parents until the children become 21. 1902(e)(6) of (3) The agency continues to treat women eligible under the provisions of sections the Act 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. Qualified Medicare beneficiaries. In determining countable income for qualified f. 1905(p)(1), 1902(m)(4), and 1902(r)(2) of Medicare beneficiaries covered under section 1902(a)(10)(E)(1) of the Act, the following the Act methods are used:

> The methods of the SSI program only. <u>X</u>

- 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.

TN NO. 92-1 7/1/92 Effective Date Supersedes Approval Date 10/29/92 91-21 TN NO.



9)

1

()

H

S	tate:	HA	WAII		
Citation		Condit		Condition or Requirement	
			amov in tit: "tri the end: the	in individual receives a title II ints attributable to the most re- the monthly insurance benefit as a II COLA is not counted as in insition period" beginning with title II benefit for December is ng with the last day of the mo- month of publication of the re- ral poverty level.	a result of a come during a January, when received, and nth following
			pove day	individuals with title II income rty levels are not effective un of the month following the sition period.	til the first
			rev	individuals not receiving title I sed poverty levels are effective date of publication.	I income, the no later than
1905(s) of th	he Act	g.	(1)	Qualified disabled and working	individuals.
				In determining countable income disabled and working individ under 1902(a)(10)(E)(ii) of t methods of the SSI program are	uals covered the Act, the
1905(p) of th	ne Act		(2)	Specified low-income Medicare b	eneficiaries.
	•			In determining countable income low-income Medicare beneficia under 1902(a)(10)(E)(iii) of same method as in f. is used.	ries covered

0

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

TN

Revision:	HCFA-PM-9 AUGUST 199	1	ATTACHMENT 2.6-A Page 13 Omb No.: 0938-	
	State:	HAWAII		
Citation		Condition or Requirement		
1902(k) of Act	the 2	. Medicaid Qualifying Tru	usts	
1		In the case of a Medicaid qualifying trust described in section 1902(k)(2) of the Act, the amount from the trust that is deemed available to the individual who established the trust (or whose spouse established the trust) is the maximum amount that the trustee(s) is permitted under the trust to distribute t the individual. This amount is deemed available to the individual, whether or not the distribution is actually made. This provision does not apply to any trust or initial trust decree established before April 7, 1986, solely for the benefit of a mentally retarded individual who resides in an intermediate care facility for the mentally retarded.		
		described above i determines that i	not count the funds in a trust as in any instance where the State it would work an undue hardship. <u>ATTACHMENT 2.6-A</u> specifies what idue hardship.	
1902(a)(10 of the Act		. Medically needy income family size.	levels (HNILe) are based on	
		all covered medically n	ENT 2.6-A specifies the MNILs for eedy groups. If the agency e levels under section 1902(f) of o indicates.	

TN No. 91-21 Supersedes TN No. 88-18	Approval Date	10/13/92	Effective Date
TN No. 88-18			HCFA ID: 7985E

Revision:	HCFA-PM-91-4 AUGUST 1991	(BPD)	ATTACHMENT 2.6-A Page 14
	State:	HAWAII	OMB No.: 0938-

Citation	Condition or Requirement			

42 CFR 435.732, 4. Handling of Excess Income - Spend-down for the 435.831 Medically Needy in All States and the Categorically 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 mixing one as ______month(S) (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
TH NG00-10			HCFA ID: 79858

Revision: HCFA R/O March 1996

ATTACHMENT 2.6A Page 14aa

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

uirement
Ū

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:	(BP) HAV	D)	Page 15	ENT 2.6-A : 0938-
Citati	on		Condit	ion or Requirement	
	b.	Categ	orically Need	y - Section 1902 [[1 States
42 CFR 435.732		provi: follo	sions of sect wing amounts	the following poli ion 1992(f) of the are deducted from i vidual's countable	Act. The ncome to
		(1)	Any SSI bene	fit received.	
		(2)	the scope of 1616 or 1634 within the	pplement received t an agreement descr of the Act, or a S cope of section A)(ii)(XI) of the A	ibed in section tate supplement
		(3)	\$\$435.134 an in that sect	OASDI that are ded d 435.135 for indiv ion, in the manner that section.	iduals specif
		(4)	Other deduct plan at <u>Atte</u>	ions from income des chment 2.6-A. Supple	scribed in this ment 4.
		(5)	Incurred exp remedial ser	enses for necessary vices recognized un	medical and der State law.
1902(a)(17 Act, P.L.) of the 100-203	by a expension party	third party a ses are subject that is a pu	that are subject to re not deducted unli- ct to payment by a blicly funded progra a State or local go	ess the third mm (other

 \bigcirc

TN No. 91-21			
Supersedes TN No. 88-18	Approval Dat	10/13/92	Effective Date 10/01/91
			HCFA ID: 79858

Revision:	HCFA-PM-91-4 August 1991	(BPD)	ATTACHMENT 2.6-A Page 16a			
	State:	HAWAII	OMB No.: 0938-			
Citation		Condition or Requirement				
	5. <u>M</u> e	thods for Det	ermining Resources			
1902(a)(10 1902(a)(10 1902(m)(1) and (C), a 1902(r) of))(C), (B) Indi	under section the agency un treatment of X. The me SSI me	thods of the SSI.programs thods and/or any more liberal methods Bed in Supplement 8b to ATTACHMENT			
		indivi the Ac SSI pr descri Supple	is that are more restrictive (except for duals described in section $1902(m)(1)$ of t) and/or more liberal than those of the ogram. Supplement 5 to ATTACHMENT 2.6-A bes the more restrictive methods and ment 8b to ATTACHMENT 2.6-A specifies the iberal methods.			

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

Ĺ

.

Revision:	HCFA-PM-91-4 AUGUST 1991	(BPD)	ATTACHMENT 2.6-A Page 17	
	State:	HAW	NII	OMĒ No.: 0938-	
Citation		Condition or Requirement			
		the liv	determining relative agency considers onl ing in the same house uses.	financial responsibility y the resources of spous- hold as available to	
1902(a)(10 1902(a)(10 1902(m)(1) 1902(r) of)(C), (B), and	the ag	individuals. For bli ency uses the followi ent of resources:	nd individuals ng methods for	
Act	che .	<u>×</u>	The methods of the SS	I program.	
			SSI methods and/or an methods described in <u>ATTACHMENT 2.6-A</u> .	y more liberal Supplement 8b to	
			Supplement 5 to ATTAC	se of the SSI program. HMENT 2.6-A describe the ods and Supplement 8b to	

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

	Approval De	ate 10/13/92	Effective Date 10/01/91
TN NO.			HCFA ID: 7985E

Revision:	HCFA-PM-91-4 August 1991	(BPD)	ATTACHMENT 2.6-A Page 18		
	State:	HAWAII	OMB No.: 0938-		
Citation		Condition or Requirement			
1902(a)(10 1902(a)(10 1902(m)(1) and (C), 4 1902(r)(2) the Act	D)(C),)(B) and	<u>covered under</u> <u>the Act</u> . The methods for 1 <u>X</u> The methods 	viduals. including individuals section 1902(a)(10)(A)(11)(X) of agency uses the following the treatment of resources: thods of the SSI program. thods and/or any more liberal methods bed in <u>Supplement Sa to ATTACHMENT 2.6-A</u> . that are more restrictive (except for		
		individ the Act the SS descril and mos	iuals described in section $1902(m)(1)$ of t) and/or more liberal that those under I program. More restrictive methods are bed in <u>Supplement 5 to ATTACHMENT 2.6-A</u> re liberal methods are specified in ment <u>3b to ATTACHMENT 2.6-A</u> .		
		agency consid in the same in resources of	ng relative financial responsibility, the ders only the resources of spouses living household as available to spouses and the parents as available to children living until the children become 21.		
1902(1)(3) and 1902(r)(2) of the Act	r)(2)	sections 190	L pregnant women covered under 2(a)(10)(A)(1)(IV) and A)(11)(IX)(A) of the Act.		
		The agency us the treatmen	ses the following methods in t of resources.		
11. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1		The me	thods of the SSI program only.		
		libera	thods of the SSI program and/or any more 1 methods described in <u>Supplement 5a or</u> ment 6b to ATTACHMENT 2.6-A.		

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

Revision:	HCFA-PM-91-4 August 1991	(81	(סי	ATTACHMENT 2.6-A Page 19
	State:	HAW		OMB No.: 0938-
Citati	on		Conditio	on or Requirement
			SSI. The more	are more liberal than those of a liberal methods are specified i or Supplement 8b to ATTACHMENT
		<u>_X</u>	Not applicable resources in c	. The agency does not consider letermining eligibility.
	ş	in th resou	y considers on) to same househo) trees of parents	tive financial responsibility, they the resources of spouses living as available to spouses and the as available to children living the children become 21.
1902(1)(3) 1902(r)(2)		<u>Pover</u> 1902 (ty level infant a)(10)(A)(1)(I)	s covered under section 1) of the Act.
the Act			igency uses the creatment of res	following methods for ources:
			The methods of plan.	the State's approved AFDC
1902(1)(3) of the Act			State's approv restrictive), 1902(1)(3)(C)	iberal than those in the ed AFDC plan (but not more in accordance with section of the Act, as specified in of ATTACHMENT 2.5-A.
1902(r)(2) of the Act			State's approv restrictive),	iberal than those in the ed AFDC plan (but not more as described in <u>Supplement 5a or</u> to ATTACHMENT 2.6-A.
		<u> </u>	Not applicable resources in d	. The agency does not consider

 \bigcirc

·

•

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

1

State: HAWAII

Citation

Condition or Requirement

1905(p)(1) (C) and (D) and	5. h. <u>Qualified Medicare beneficiaries covered under</u> section 1902(a)(10)(E)(1) of the Act	-
1902(r)(2) of 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> ATTACHMENT 2.6-A.

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	Approval Date 10/13/02	Effective Date _ 10/01/91
TH NO.		HCFA ID: 7985E

Revision:	HCFA-PM-9 August 199 State:	1	(BPD) Hawaii	ATTACHMENT 2.6-A Page 21a OMB No.: 0938-
Citati	Ion		Conditio	on or Requirement
1902(m)(1) and (m)(2) of the Act)(B)	•.	section 1902(m)(1) o	ed individuals described in of the Act who are covered (10)(A)(ii)(X) of the andard is:
	15,84		X Same as SSI re:	source standards.
			which are high	dically needy resource standards, wer than the SSI resource the State covers the medically
			Supplement 2 to ATTA	CHMENT 2.6-A specifies the these individuals.

TN No. 91-21 Supersedes	Approval Date	10/13/92	Effective Date	10/01/91
TN No.		-	HCPA ID: 7985	S as a chiefe

ATTACHMENT 2.6-A Page 22

Citation	Condition or Requirement
	7. Resource StandardMedically Needy
	a. Resource standards are based on family size.
1902(a)(10)(C)(l) of the Act	 A single standard is employed in determining resource eligibility for all groups.
	C. In 1902(f) States, the resource standards is more restrictive than in 7.b. above for
	Aged
kie na star i	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.
1000/->//0//5>	8. Resource Standard Qualified Medicare Beneficiaries, Specified Low-Income Medicare Beneficiaries and Qualifying Individuals
1902(a)(10)(E), 1905(p)(1)(C),	For qualified Medicare 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.

1902(a)(10)(E), 1905(p)(1)(C), 1905(p)(2)(B) and 1860D-14(a)(3)(D) of the Act

.

ATTACHMENT 2.6-A Page 22a

State: Hawaii

9.

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

44

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.

Revision:	HCFA-PM-91-4 AUGUST 1991	(BPD)	ATTACHMENT 2.6-A Page 23
	State:	HAWAII	OMB No.: 0938-
Citati	on	Conditio	on or Requirement
	10.	Excess Resources	
	A .	Categorically Needy Beneficiaries, and (Individuals	, Qualified Medicare Qualified Disabled and Working
		Any excess resources	s make the individual ineligible
	ъ	Categorically Needy	Only
		SSI. Receipt	s a section 1634 agreement with of SSI is provided for hile disposing of excess
	c	Medically Needy	

Any excess resources make the individual ineligible.

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

2

Revision:	HCFA-PM-91-4 August 1991	(BPI			ATTACHMENT 2.6-A Page 24 OMB No.: 0938-
	State:	HAWAI	I		
Citatic	on		Co	ndition	or Requirement
42 CFR	11.	Effect	tive Date	of Elig	ibility
435.914	a.	, Groups	s Other T	han Qual:	ified Medicare Beneficiaries
		(1)	For the	prospect:	ive period.
	,		Coverage	is avai: g individ	lable for the full month if th
			X ·· Age	ed, blin DC-relati	d, disabled. ed.
			www.ang L	HE BONCA	lable only for the period for which the following the eligibility requirements.
			- Ag		d. disabled.
		(2)	For the	retroact:	ive period.
			the date	als would	lable for three months before loation if the following i have been eligible had they
			Åg	ed, blind DC-relate	i, disabled. M.
			of the the applicat have been	hird mont ion if the n eligible	Lable beginning the first day th before the date of he following individuals would le at any time during that applied
			X Ag	ed, blind DC-relate	t, disabled. M.
TN No. 93 Supersedes TN No	1-21 Appro	oval Dat	te <u>10/13</u>	/ 92	Effective Date <u>10/01/91</u> HCFA ID: 7985E

•

٠

ATTACHMENT 2.6-A Page 25

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

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: HAWAII

Citation(=)	Condition of	r Requirement
1920(b)(1) of the Act	(3)	For a presumptive eligibility period for pregnant women only.
		Coverage is available for ambulatory b prenatal care for the period that begins on the day a qualified provider
•		determines that a woman meets any of the income eligibility levels specified
		in ATTACHENT 2.6-A of this approved plan. If the woman files an
		application for Medicaid by the last day of the month following the month in
		which the qualified provider made the
		determination of presumptive eligibility, the period ends on the day
		that the State agency makes the determination of eligibility based on
	1	that application. If the woman does
		not file an application for Medicaid by the last day of the month following the
	-	month in which the qualified provider made the determination, the period ends on that last day.
1902(e)(8) and 1905(a) of the	de	r qualified Medicare beneficiaries fined in section 1905(p)(1) of the
Act		t coverage is available beginning with e first day of the month after the month
	in	which the individual is first determined be a qualified Medicare beneficiary under
	80	ction 1905(p)(1). The eligibility termination is valid for-
	х.	12 months
		6 months
•	_	months (no less than 6 months and no more than 12 months)

81.1411

BCFA-FM-95-1 March 1995 Revisions (10) ATTACHMENT 2.6-A Page 26

Citation	*	Condition or Reguirement
1902(a)(10) and 1902(f) of the Act	12.	Pre-OBRA 93 Transfer of Resources - Categorically and Medically Reedy, Qualified Medica Beneficiaries, and Qualified Disabled and Worki Individuals
		The agency complies with the provisions of section 19 of the Act with respect to the transfer of resource
		Disposal of resources at less than fair market val affects eligibility for certain services as detail in <u>Supplement 9 to Attachment 2.6-A</u> .
1917(c)	13.	Transfer of Assets - All eligibility groups
		The agency complies with the provisions of section 1917(c) of the Act, as enacted by OBRA 93, with regate to the transfer of assets.
		Disposal of assets at less than fair market val affects eligibility for certain services as detail in <u>Supplement 9(a) to ATTACHENT 2.6-A</u> , except instances where the agency determines that the transfer rules would work an undue hardship.
1917(d)	14.	Treatment of Trusts - All eligibility groups
		The agency complies with the provisions of section 1917(d) of the Act, as amended by OBRA 93, with regar to trusts.
		The agency uses more restrictive methodologic under section 1902(f) of the Act, and applic those methodologies in dealing with trusts;
		The agency mosts the requirements in section 1917(d)(f)(B) of the Act for use of Mille trusts. by
		The agency does not count the funds in a trust in an instance where the agency determines that the transfe would work an undue hardship, as described is Supplement 10 to ATTACHENT 2.6-A.

TH No. 96-005 Supersectors TH No. 91-21 Approval Date OCT 1 1 1995 Effective Date LAN 0 1 1000

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:				
	<u>X</u> 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.

0.

Approval Date 12/11/95

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

)

SUPPLEMENT 1 TO ATTACHMENT 2.6-Page 5

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: HAWAII

INCOME BLIGIBILITY LEVELS (Continued)

3. Aged and Disabled Individuals

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

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

Family Size	Income Level
1 /	8_+
2	8 <u>+</u>
3	s+
4	5_+
5	5 . +

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 Federal poverty level.

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.

*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. 92-15 Supersedes TN No. 91-21	Approval Date	10/29/92	Effective Date	7/1/92
	TR NO. <u>91-21</u>			BCTA ID:	7985E

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 $1905(p)(2)(\lambda)$ 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

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

	Approval	Date	10/13/92	Effective	Date 10/01/91
TN No.	20 B			HCFA ID:	79852

Revision: HCFA-PM-91-4 (BPD) AUGUST 1991 SUPPLEMENT 1 TO ATTACHMENT 2.6-A Page 7 ONB 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
- 2. <u>SECTION 1902(1) STATES WHICH AS OF JANUARY 1, 1987 USED INCOME STANDARDS</u> MORE RESTRICTIVE THAN SSI
- a. Based on the following percent of the official Federal income poverty level:

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

b. Levels:

Family Size

Income Levels

\$_	*	
\$_		
		17

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

TN No. 91-21 Supersedes	Approval	Date	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)	(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 ^{1/2}	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}
1.1	Urban only			
	Urban & rural			
1	\$ 469	S	\$	S
2	\$ 632	S	\$	5
3	\$ 795	S	5	S
4	\$ 958	\$	\$	S
For each Additional Person,				
Add:	\$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 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)

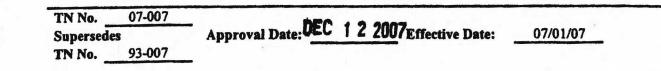
D. MEDICALLY NEEDY

¥

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)	(5)
Family Size	Net income level protected for maintenance for one month	Amount by which Column (2) exceeds limits specified in CFR 435.1007 ^{1/2}	Net income level for persons living in rural areas for months	Amount by which Column (4) exceeds limits specified in 42 CFR 435.1007 ¹¹
	urban only urban & rural			
2.5		i ji si si s		1.1.1.1.1
5	\$ 1.121	<u> </u>	<u> </u>	5
6	\$ 1,284	<u> </u>	5	5
7	\$ 1.447	\$	\$	5
8	\$ 1.610	5	5	5
9	\$ 1,772	5	\$	S ·
10	\$ 1,935	\$	\$	\$
For each Additional Person, Add:	\$ 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
,	
_2	
·	
5	

IXI

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

TN No. 91-21 Supersedes	Approval	Date _	10/13/92	Effective		Date 10/01/91	
TN No		31.4		HCFA	ID:	79858	

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

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

Family Size	Resource Level
_1	2.000
2	3,000
	3,250
4	3,500
_3	3,750
_6	4,000
_7	4,250
	4,500
_9	4,750
10	5,000
For each additional person	250

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

Revision: HCFA-PM-85-3

(BERG)

SUPPLEMENT 3 to ATTACHMENT 2,6-A Page 1

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State HAWAII

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

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		Approval Date:	AUG-2-3 2010	Effective Date:	10/01/09
TN No.	85-9		100-5-0 2010		
					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. <u>91-21</u> Supersedes TN No. <u>88-13</u>	Approval	Date	10/13/92	Effective	Date 10/01/91
TH NO00-13				HCFA ID:	79858

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

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: HAWAII

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						2.1
Supersedes	Service .	Approval	Date:	09/30/2013	Effective	Date:	01/01/2014
TN No.	91-21				· · · _ · ·		

Revision: HCFA-PM-91→ (BPD) AUGUST 1991 SUPPLEMENT 54 TO ATTACHMENT 2.6-A Page 1 OMB No.: 0932-

.

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.

Supersedes	Approval	Date	10/13/92	Effective	Date 10/01/91
TN NO		1		HCFA ID:	7985E

State: <u>Hawaii</u>

Standards for Optional State Supplementary Payments

Payment Category	Admini	stered by		Inco	ome Level		Income Disregards
(Reasonable Classification)	Federal	Federal State		<u>Gross*</u>		<u>Net**</u>	
			1 person	Couple	1 person	Couple	
(1)	7.0	(2)	(3)		(4)		(5)
A, B, D IN DOMICILIARY CARE:	x			<u>n.</u> 18			
LEVEL I	\$735.00	\$651.90	\$2,205.00	N/A	\$1,386.90	N/A	
LEVEL II	\$735.00	\$759.90	\$2,205.00	N/A	\$1,494.90	N/A	

NOTE: *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

TN No. Supersedes	17-0001	Approval Date:	J u n e 15, 2017	Effective Date:	01/01/2017
TN No.	15-001	<u> </u>			

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

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. 91-21 Supersedes TH No. 89-7	Approval	Date	10/13/92	Effective	Date
TH NO.					79852

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

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

	Approval	Date	10/13/92	Effective	Date	10/01/91
TH No.				HCTA TD.	79852	

Revision: HCFA-PM-91-4 August 1991

State:

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

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

(BPD)

HAWAII

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

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. <u>Wages paid by the Census Bureau for temporary employment related to census activities are</u> excluded for the eligibility groups:

Mandatory Categorically Needy Eligibility Groups

	longer eligible for SSI because of	§1902(a)(10)(A)(i)(II)
-	finition of disability.	
2. Qualified pre	-	§1902(a)(10)(A)(i)(III), §1905(n)(1)
3. Qualified chi	ldren.	§1902(a)(10)(A)(i)(III), §1905(n)(2)
4. Poverty level	pregnant women.	§1902(a)(10)(A)(i)(IV), §1902(l)(1)(A)
5. Poverty level	infants.	§1902(a)(10)(A)(i)(IV), §1902(l)(1)(B)
6. Poverty level	children under age 6.	§1902(a)(10)(A)(i)(VI), §1902(l)(1)(C)
	children under age 19.	§1902(a)(10)(A)(i)(VII), §1902(l)(1)(D)
8. Disabled indi	ividual whose earnings exceed al gainful activity level.	§1619(a)
9. Disabled indi	vidual whose earnings are too /e SSI cash benefit.	§1619(b)
10. Disabled indi	vidual whose earnings are too ve SSI cash benefit.	§1902(a)(10)(A)(i)(II), §1905(q)
11. Pickle amend	ment -Would be eligible for SSI As were deducted from income.	Section 503 of P.L. 94-566
12. Disabled wid	ows/widowers.	§1634(b), §1935
13. Disabled adu	lt children.	§1634(c), §1935
14. Early widows	/widowers.	§1634(d), §1935
	abled and Working Individuals.	§1902(a)(10)(E)(ii), §1905(s)
	dicare Beneficiaries.	§1902(a)(10)(E)(i), §1905(p)(1)
	v Income Beneficiaries.	§1902(a)(10)(E)(iii)
TN No. 08-017	- FEB 1 3 200	۵

Supersedes TN No. 08-004 Approval Date: FEB 1 3 2009 Effective Date:

10/01/2008

Revision:	HCFA-PM-91-4 August 1991	(BPD)	SUPPL Page 2 OMB N		ENT 8a to ATTACHMENT 2.6-A 0938-
18. Qua	lified Individuals -I.		ş	190	2(a)(10)(E)(iv)(I)
Optiona	al Categorically Need	ly Eligibility			
the a	t the income and reso appropriate cash assist FDC).	-		190	2(a)(10)(A)(ii)(I)
requi	ild meet the income an irements of AFDC if from earnings rather icy.	child care cos	ts were	190	2(a)(10)(A)(ii)(II)
or SS instit recei	Id be eligible for cash SI) if they were not in tution. Receiving, or v ve if they were not in tution, a State supplem	a medical would be eligi a medical	ble to	190	2(a)(10)(A)(ii)(IV)
	viduals under age 21 vition agreements.	vho are under	State §	190	2(a)(10)(A)(ii)(VIII)
does	l or disabled individua not exceed 100 perce rty level.			190	2(a)(10)(A)(ii)(X)
which	iving only an optional h is more restrictive the otional State supplement	han the criteri	a for	1902	2(a)(10)(A)(ii)(XI)
-	onal targeted low inco	me children.			2(a)(10)(A)(ii)(XIV)
8. Medi	cally Needy.		ş	1902	2(a)(10)(C), §1902(a)(10)(C)(i)(III)

Approval Date: FEB 1 3 2009 Effective Date:

10/01/2008

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

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			2.2.2			

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

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

Revision: HCFA-PM-91-4 August 1991

A-PM-91-4 (BPD) st 1991 SUPPLEMENT 8a to ATTACHMENT 2.2-A Page 1 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			1, -1			1 4000
Supersedes	Approval Date:	JUL	11	1000 Effective Date:	AVE	
TN No.				HCFA ID: 79	85E	

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

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: HAWAII

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						- T
Supersedes	1. N. 1.	Approval	Date:	09/30/2013	Effective	Date:	01/01/2014
TN NO.	03-001	•					

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

:

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

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

1

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

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State:	HAWAII	
State:	IMMALL	 -

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.

TN No. 91-21 Supersedes	Approval	Date	10/13/92	Effective	Date _	10/01/91
TN No. 85-5				HCFA ID:	7985E	

Revision: HCFA-PM-91-4 (BPD) AUGUST 1991 SUPPLEMENT 9 TO ATTACHMENT 2.6-A Page 3 OMB No.: 0938-

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: ______HAWAII

1

 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:

TN No. <u>91-21</u> Supersedes	Approval Date	10/13/92	Effective	Date .	10/01/91
TN No. <u>85-5</u>			HCFA ID:	7985E	

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

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. []

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:

TN No. <u>91-21</u> Supersedes	Approval Date _	10/13/92 Ef	fective	Date 10/01	/91
TN No. <u>85-5</u>		HC	FA ID:	79852	

\$

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

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State:	 HAWAII			_				
	No individual	iŝ	ineligible	by	reason	of	item	A.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;
- (11) 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.

TN No. 91-21 Supersedes	Approval	Date	10/192	Effective	Date _10/01/01
TN No. <u>85-5</u>				HCFA ID:	79858

1

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:
 - 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:

TN No. <u>91-21</u> Supersedes TN No. <u>85-5</u>	Approval Date	10/13/92	Effective	Date 10/01/91
			HCFA ID:	79852

1

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

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: ______ HAWAII

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. <u>91-21</u> Supersedes	Approval	Date	10/13/92	Effective	Date 10/01/91	
TN No. 90-16				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: HAWAII

(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.

ì

SUPPLICENT 9(a) to ATTACHDENT 2.6-A Pege 1

STATE FLAS UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: HAWAII

TRANSFER OF ASSETS

- The agency provides for the denial of certain Medicaid services by reason 1917(c) of disposal of assets for less than fair market value.
 - Institutionalized individuals may be denied certain Medicaid 1. 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:

> The agency applies these provisions to the following non-institutionalised 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. 95-005 Supersedes	Approval Date	OCT 1 1 1996	Effective Date	WAN 01 THE
TH No.	_	•		

State: HAWAII

TRANSFER OF ASSETS

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

5.

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:

Revision: HCFA-PM-95-1 (MB) March 1995 SUPPLEMENT 9(a) to ATTACHMENT 2.6-A Page 3

State: HAWAII

TRANSPER 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.
- ь.

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:

State:

TRANSFER OF ASSETS

- 9. 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 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.
- (b) If one spouse is no longer subject to a penalty, the remaining penalty period must be served by the remaining spouse.
- 10. Treatment of income as an asset-

(MB)

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. Imposition of a penalty would work an undue hardship-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.

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 cartain 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:

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						
Supersede	18	Approval Date:	SEP	7 2010	Effective Date:	10/01/09	
TN No.	NEW				1		

2

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State HAWAII

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

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:

TN No.	09-012						
Superseder	3	Approval Date:	SEP	7 2010	Effective Date:	10/01/09	
TN No.	NEW						

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

6.

7.

- 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.
- (b)

If one spouse is no longer subject to a penalty, the remaining penalty period must be served by the remaining spouse.

TN No.	09-012			7 0010	
Supersede	15	Approval Date:	SEP	7 2010 Effective Date:	10/01/09
TN No.	NEW				

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State _____

HAWAIL

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.

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

X For transfers of the right to an income stream, the agency will base 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.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State HAWAII

TRANSFER OF ASSETS (cont.)

10.

Procedures for Undue Hardship Waivers

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

- 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.

11. 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			- 0010		
Supersede	8	Approval Date:	SEP	7 2010Effective Date:	10/01/09	
TN No.	NEW					

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

SUPPLEMENT 10 to ATTACHMENT 2.6-A Page 1

STATE PLAN 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. <u>90-8</u> Supersedes	Approval I	Date _	<u>11/12/</u> 90 Ef	fectiv	e Da	ate _	7/1/90
TN NO				HCFA	ID:	4093E	/0002P

R .

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

0

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: HAWAII

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..90-16SupersedesApproval Date3/1/91Effective Date10/1/90TN No.89-10

SUPPLEMENT TO 15a TO ATTACHMENT 2.6-A Page 1

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: HAWAII

ELIGIBILITY CONDITIONS AND REQUIREMENTS

ELIGILBITY UNDER SECTION 1925 OF THE ACT TRANSITIONAL MEDICAL ASSISTANCE

The State covers low-income families and children for Transitional Medical Assistance (TMA) under section 1925 of the Social Security Act (the Act). This coverage is provided for families who no longer qualify under section 1931 of the Act due to increased earned income, or working hours, from the caretaker relative's employment, or due to the loss of a time-limited earned income disregard. (1902(a) (52), 1902(e) (1), and 1925 of the Act)

The amount, duration, and scope of services for this coverage are specified in Section 3.1. of this State Plan. i

For Medicaid eligibility to be extended through TMA, families must have been Medicaid eligible under section 1931 (months of retroactive eligibility may be used to meet this requirement):

- During at least 3 of the 6 months immediately preceding the month in which the family became ineligible under section 1931.
- For fewer than 3 of the 6 previous months immediately preceding the month in which the family became ineligible under section 1931. Specify:

The State extends Medicaid eligibility under TMA for an initial period of:

- 6 months. For TMA eligibility to continue to into a second 6- month extension period, the family must meet the reporting, technical, and income eligibility requirements specified at section 1925(b) of the Act.
- 12 months. Section 1925(b) does not apply for a second 6-month extension period.

The State collects and reports participation information to the Department of Health and Human Services as required by section 1925(f) of the Act, in accordance with the format, timing, and frequency specified by the Secretary and makes such information publicly available.

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

- 2. System Development
 - A. _____ The Agency itself will build and maintain an AVS.
 - In 3 below, describe how the system will meet the requirements in Section 1.
 - B. X 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 requirements in Section 1.

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 eduit disabled child residing in the individual's home, when the individual's equity interest in the home exceeds the following amount:

\$500,000	(increased by the annual percentage increase in the urban
	component of the consumer price index beginning with 2011, rounded to the nearest \$1,000).

X 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		CCD	1 2010		
Supersede	8	Approval Date:	SEP	1 2010 Effective Date:	10/01/09	
TN No.	NEW	The Wart St.				

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

	ions Within New Adult Group	Applicable Population Adjustment				
Population Group	Relevant Population Group Income Standard For each population group, indicate the lower of:	Resource Proxy	Enrollment Cap	Special Circumstances	Other Adjustments	
	 The reference in the MAGI Conversion Plan (Part 2) to the relevant income standard and the appropriate cross-reference, or 133% FPL. If a population group was not covered as of 12/1/09, enter "Not covered". 	indicate if population g	the population	or "NA" in the appropr adjustment will apply additional information	to each	
A	в	с	D	E	F	
Parents/Caretaker Relatives	Attachment A, column C, Line 1 of Part 2 of the CMS approved MAGI Conversion Plan, including any subsequent CMS approved modifications to the MAGI Conversion Plan	No	No	No	No	
Disabled Persons, non-institutionalized	Attachment A, column C, Line 2 of Part 2 of the CMS approved MAGI Conversion Plan, including any subsequent CMS approved modifications to the MAGI Conversion Plan	No	No	No	No	
Disabled Persons, institutionalized	Attachment A, column C, Line 3 of Part 2 of the CMS approved MAGI Conversion Plan, including any subsequent CMS approved modifications to the MAGI Conversion Plan	No	No	No	No	
Children Age 19 or 20	NA	NA	NA	NA	NA	
hildless Adults	Attachment A, column C, Line 5 of Part 2 of the CMS approved MAGI Conversion Plan, including any subsequent CMS approved modifications to the MAGI Conversion Plan	No	Yes	No	No	

Table 1: Adult Group Eligibility Standards and FMAP Methodology Features

 TN No.
 14-002

 Supersedes
 Approval Date:
 05/16/2014
 Effective Date:
 01/01/2014

 TN No.
 NEW

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				

- 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.

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 1/23/2014.
- 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).

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

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.

TN No.	14-002						
Supersedes		Approval	Date:	05/16/2014	Effective	Date:	01/01/2014
TN No.	NEW	9 m. 19 m.					

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

HAWAII -

02/28/2014

	Population Group	Net standard as of 12/1/09	Converted standard for FMAP 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)
	A	В	с	D	E	F
Con	versions for FMAP Claiming Purposes					
1	Parents/Caretaker Relatives	100%	100%	yes	Part 1 of approved state MAGI conversion plan	SIPP
2	Non-institutionalized Disabled Persons FPL %	100%	100%	n/a	new SIPP conversion	SIPP
3	Institutionalized Disabled Persons	100%	100%	n/a	new SIPP conversion	SIPP
4	Children Age 19-20	n/a	n/a	n/a	n/a	n/a
5	Childless Adults	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.

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

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%

TN No.	14-002				
Supersedes	2016 S. 107	Approval Date:	05/16/2014	Effective Date:	01/01/2014
TN No.	NEW			_	

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.

TN NO.	14-002	10.7% Da. 170			
Supersedes		Approval Date:	05/16/2014	Effective Date:	01/01/2014
TN NO.	NEW			7	

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.

TN No.	14-002		1 Sec. 19		
Supersedes		Approval Date:	05/16/2014	Effective Date:	01/01/2014
TN NO.	NEW			and the second second	

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

- The state sent notices in both August and September 2013 to current beneficiaries informing them of the upcoming changes in eligibility and expansion program.
- 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.

TN No.	14-002				
Supersedes		Approval Date:	05/16/2014	Effective Date:	01/01/2014
TN NO.	NEW	그런 것이 가슴	je staling and staling		나는 가유는 것 가 드릴

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		

.

· () ·

 \bigcirc



Medicaid Eligibility

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

.

hat	e Residency				
71	The state provides Medicaid to otherwise eligible residents of the state, including residents who are absent from the state under certain conditions.				
	Individuals are considered to be residents of the state under the following conditions:				
	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.				
	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 the institution by another state.				
	IV-E eligible children living in the state, or				



..

۰.

Otherwise meet the requirements of 42 CFR 435.403.

Approval Date: 09/26/2013 \$88-2

-	-	The first of the	ai.
and the second			•
-			
line		net to	- 31
	-	han a dinan	A CONTRACTOR

Meet the criteria specified in an interstate agreement.

• Yes O No

The state has interstate agreements with the following selected states:

🔀 Alabama	X Illinois	Montana 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	X Texas
Colorado	🔀 Louisiana	New Mexico	🔀 Utah
Connecticut	Maine	New York	Vermont
Delaware	Maryland	X North Carolina	Virginia
District of Columbia	Massachusetts	X 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.



· daile . ner years - and ha

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

the bie in which

• 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

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.

SUPERSEDING PAGES OF STATE PLAN MATERIAL

 \bigcirc

(

SUPERSEDING PAGES OF STATE PLAN MATERIAL				
TRANSMITTAL NUMBER:	STATE:			
13-0007-мм6	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			



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

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:

TN No: 13-0007-MM6

Approval Date: 09/13/2013 S89-1 Effective Date: 10/01/2013

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;

	Cian.	in the second	"A traffic	1. 1. 1.
	1º mar	Stin		1000
		W .		6
	Coner.	1		1. 1.
1	·	-		-

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

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

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.

SUPERSEDING PAGES OF STATE PLAN MATERIAL

TRANSMITTAL NUMBER:

STATE: Hawaii •

13-0007-MM1

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
Attachment 2.2-A	Page 1 Page 3 Page 3 Page 4 Page 4 Page 12 Page 13 Page 13 Page 14 Page 14 Page 21 Page 23	Page 2, A.2.b Page 2, A.2.c Page 2a, A.3 Page 9c, B.1 remove "Caretaker relatives" and "Pregnant women" Page 20, B.14 Page 23c, B.19 Page 23c, B.22 Page 25, C.4
Supplement 1 to Attachment 2.2-A	Page 23b Page 1	
Attachment 2.6-A	Page 3b Page 11a Page 16 Page 19 Page 19a Page 19b Page 21	Page 1, A.2.a(i) and (iii) Page 6 related to AFDC recipients, pregnant women, infants, and children 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	

Supplement 5a to Attachment 2.6-A		Page 1, "Pregnant womeń 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	

 \bigcirc



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

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



	Household size	Standard (\$)	Additional incrementa • Yes O No				
	1	493	Increment amount \$	110			
	2	653					
	3	795		· · · •			
	4	938	Contraction of		····		
	5	1,083					
	6	1,232					
	7	1,391					
	8	1,508					
	9	1,623					
	10	1,739					-
	11	1,857				-	
	12	1,974					
	13	2,091					
	14	2,208					
	15	2,325					
O T	dollar amounts incre Yes No dard is as follows: matewide standard	ase automatically ea	ch year				
	andard varies by reg	ion					
00	andard varies by livi	ng arrangement					

Effective Date: 1/01/2014

1.

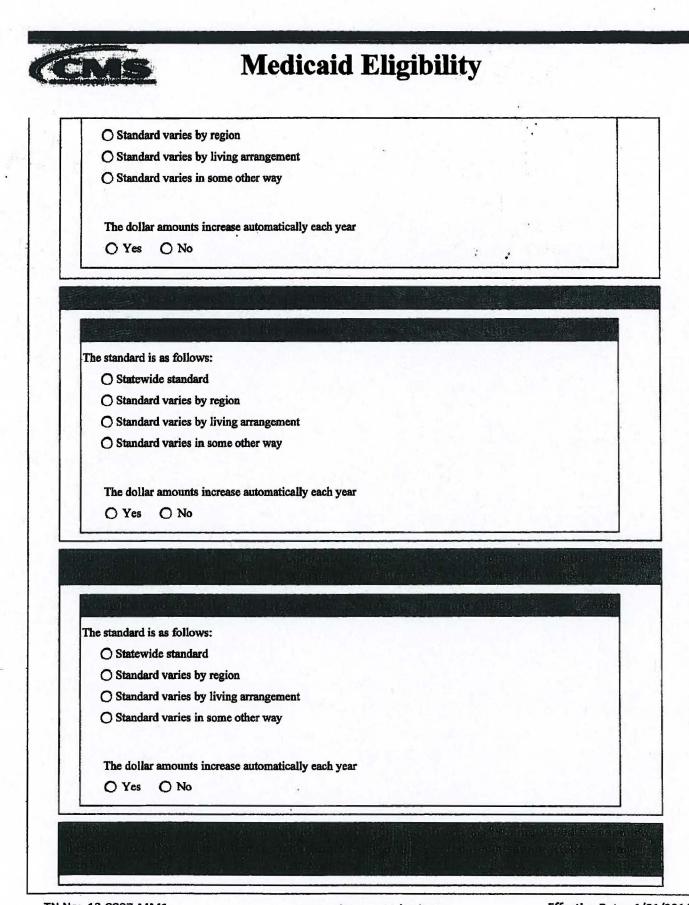


	Household size	Standard (\$)	Additional incremental amount • Yes • No		
1		418	Increment amount \$ 146		
2		565			
3		712		4 4	
4		859	1 2 1 2 2 1 년 2		
5		1,006		1. 1.	
6		1,153			
7	ina a series	1,300			
8	6	1,446		0	
9		1,593			
10)	1,740			
11		1,887			
12	2	2,034			
13	<u>an 1997 - 1</u> 6 - 1997 1	2,181			
14		2,328			
15	5	2,475			

TN No: 13-0007-MM1 Hawaii Effective Date: 1/01/2014

. .

- Ant



TN No: 13-0007-MM1 Hawaii

Approval Date: 09/13/2013 \$14-4 Effective Date: 1/01/2014



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

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 \$14-5

Effective Date: 1/01/2014



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 S14-6



P

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 a	qualified hospitals making presumptive eligibility determinations.
• Yes O No	
Select one or both:	
	at relate to the proportion of individuals determined presumptively eligible who submit a regular at 42 CFR 435.907, before the end of the presumptive eligibility period.
Description of standards:	 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; 90% of individuals are offered help from hospital PE staff to complete the full Medicaid application; 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 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.
	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 w	vithin a calendar year.
\bigcirc No more than one period w	vithin two calendar years.
\bigcirc No more than one period w period.	within a twelve-month period, starting with the effective date of the initial presumptive eligibility
Other reasonable limitation	
	plication be signed by the applicant, parent or representative, as appropriate.
• Yes O No	
	lication form for Medicaid and presumptive eligibility, approved by CMS.
• The state uses a separate ap included.	oplication form for presumptive eligibility, approved by CMS. A copy of the application form is
	An attachment is submitted.



The The	e presumptive eligibil	ity determination is based on the following factors:		
	being determined (e.	egorical or non-financial eligibility for the group for which the individua .g., based on age, pregnancy status, status as a parent/caretaker relative, o licaid state plan or a Medicaid 1115 demonstration for that group)		
	Household income r eligibility is being d	nust not exceed the applicable income standard for the group for which etermined, if an income standard is applicable for this group.	the individual's presumptive	
\boxtimes	State residency			
\boxtimes	Citizenship, status a	s a national, or satisfactory immigration status		
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.

Who can	 You can qualify for presumptive eligibility for Medicaid if you meet
qualify for	all of these rules: Your income is below the applicable monthly limit. You are a U.S. citizen, U.S. national, or eligible non-citizen. You do not already have Medicaid. You have not had presumptive eligibility for Medicaid in the
presumptive	past 12 months. If you are pregnant, you have not had presumptive
eligibility for	eligibility for Medicaid during this pregnancy. You are in one of the groups that qualifies for presumptive
Medicaid?	eligibility for Medicaid: Children under 19 years of age Parents and caretaker relatives Pregnant women Other adults age 19 – 64 years People under age 26 who were in foster care
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	re blank if you don't have one.)		3. Apartment or suite number
4. City	:	5. State	6. ZIP code	7. County
8. Mailing address (if di	fferent 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	2	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.



10

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.

TN NO: 13-007-MM7

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.

Approval Date November 18, 2015

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.



TN NO: 13-007-MM7

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;

Approval Date November 18, 2015

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.



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 Medicald 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	 You can qualify for presumptive eligibility for Medicaid if you meet
qualify for	all of these rules: Your income is below the monthly limit. You are a U.S. citizen, U.S. national, or eligible non-citizen. You have not had presumptive eligibility for Medicaid in the
presumptive	past 12 months. If you are pregnant, you have not had presumptive
eligibility for	eligibility for Medicaid during this pregnancy. You are in one of the groups that qualifies for presumptive
Medicaid?	eligibility for Medicaid: Children under 19 years of age Parents and caretaker relatives Pregnant women Other adults age 19 – 64 years People under age 26 who were in foster care
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 ulso call 1.600-316-8005 for all DHS services.	English	
E是一封從人類臣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,你將會被前同你讓什麼語言,您的通話 \$% 被獨重直到接過翻譯服務。其他人類服務部門的服務,您可以發電到 1.800-316-8005.	Cantonese	
El taropwe mi auchchea seni ewe putain tumwunun aramas (Department of Human Services). Kose mwochen kokkori a nampan foon won na taropwe. Nupwen omw kokko, repwe eisinuk menni kkapas ke sine pwe repwe kkutta ngonuk mon choor chikau. Ka pwan cinogeni kokkori 1-800-316-8005 ren meinisina ninnis seni DHS.	Chuukese	
Ceci est une lettre importante du Department of Human Services (DHS). S'illvous plaît, faire un appel téléphonique au numéro Le téléphone situé sur la lettre. Lorsque vous téléphonez, quelqu'un va vous demander quelle langue vous partez, et votre ppel sera mis en attente pour un interprét. Vous pouvez aussi teléphoner 1-300-316-3005 pour tous les services de DHS.	French	
Jes ist eon wichtiger Brief von der Abtelung Menschlicher Dienste (DHS). Bite rufen Sie die Telefonnummer, die auf dem Brief efunden wurde. Wenn Sie rufen, werden Sie gefragt werden, welche Sprache Sie sprechen, und ihr Anruf wird auf Wartestellung ür einen Dolmetscher geschaltet werden. Sie können 1-800-316-8005 für alle DHS Dienste auch rufen.	German	
te leka koʻlkoʻi keia mai ka 'Oihana Lawelawe Kanaka (Department of Human Services). E kelepona mal i ka helu clepona ma luna o ka leka. Ke kelepona 'oe, e ninau 'ia ana 'oe he aha kau 'olelo 'oiwi a lalla e kali 'oe a loa'a ke tanaka mahele 'olelo. Hiki pu ia 'oe ke kelepona i 1-800-316-8005 no na lawelawe a pau a ka 'Oihana Lawelawe (anaka (DHS)).	Hawaiian	
Jaytoy ket importan le nga surat nga naggapu nti Department of Human Services. Pangaasi nga tawagan yoli numero hi telepono ga nakakabi hi daytoy nga surat. Nu umawag kayo, saludsuden da nu anya hi panagasaso yo ket urayen yo nga malyallatiw hi awag yo hi intepreter. Mabalin kayo nga umawayg hi 1-800-316-8005 para kadaghi amin nga serbisyo hi DHS.	llocano	
\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 こ、貴方がどの言語を話されているかを聞かれます、 道訳に接続 されるまでしばらくお待ちください。 D H S のどの ナービスにも、 この電話番号 1-800-316-8005 で対応いたします	Japanese	
11가 서비스 부서에서 보내는 중요한 편지 입니다. 이편지에 기계된 전화변호로 전화를 하시요. 당신이 전화를 할때 당신이 + 응하는 언어를 물을것이고 그언어의 통역인에게 연결할것 입니다. 당신은 모든 인간 서비스 부서(디에이치(에스)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。请按打信上的电话号码。当你打电话时,你将会被询问你讲什么语言, 发的通话将被搁置置到接通翻译服务。其他人类服务部门的服务,您可以致电到!——800-316—8005。	Mandarin	
luon 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 lo 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 ewoj juon am ri okok. Komaron call 1-800-316-8005 non aolepen ra ko kajojo ilo DHS services.	Marshallese	
D se fa'asiliasilaga ta'ua leneimai 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 Disa."	Samoan	
sina. Ésta es una carta importante de la Sección de Servicios Humanos (DHS). Por favor llame el número de teléfono ocalizado 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	
to ay mahalaga na sulat na galling sa Department of Human Services. Mangyaring tawagan ang numero na akalagay sa sulat na ito. Kung kayo ay t <u>atawag,</u> tatanungin kung ano ang iyong wika at hintayin ninyo nanggat 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 Polungaue Ngaue Ma'ae Kakai. Kataki 'o telefoni ki he fika 'oku ha 'i he tohi ni. 'E fehu'i itu 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 akatonu lea. Te ke lava 'o ta ki he ki he ngaahi tokoni kotoa 'a e DHS.	Tongan	
)ảy là là thơ quang trọng từ các Bộ Phục Vụ Nhân Dân (DHS). Làm ơn gọi xố điện thoại nằm trên là thơ. Khiban gọi, bạn lẻ được hồi ngôn ngũ nào bạn nói và cú điện thoại của bạn sẽ chở người thông dịch. Đồng thời bạn cùng có thể gọi số 190-316-8005 cho các phục vụ DHS.	Vietnamese Việt Nam	
Gini importante nga sulat gikan sa Department of Human Services (DHS). Palihug tawagi ang numero sa maong elepono nga nahimutang sa sulat. Sa imong pagtawag, ikaw pangutan-on kun unsa ang imong pinulongan ug ang mong tawag ilang jaahulat para sa usa ka taghubad sa pinulongan. Mahimo usab nga imong tawagan ang 1-800- 115-8005 para sa tanang mag serbisyo sa DHS.	Visayan	

TN NO: 13-007-MM7

DHS 1XXXX

Approval Date November 18, 2015

DHS 1XXXX

TEP-11 Tell·us·about·yours

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
--------	---------

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	Nrite 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

••• 🛧 \times

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

٩.

- •- 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					
□ ×					
¶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¶				
 Your-presumptive-eligibility-will-end-on-the-date-you If-you-are-denied,-you-will-be-referred-to-the-Connector- 	ur application for Medicaid is either approved or denied. for other affordable insurance programs.¶				
 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 	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

ſ

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

State of Hawaii - Dept. of Hum	an Services	
Med-QUEST Division Street address		
Honolulu, HI 96813		61
1214210020101010000000	a second and a s	
Applicant name: Jane Dos		
Applicant name. Jane Das	<u>.</u>	
Thank you for your Hospit	al Presumptive Eligibility (HPE) application dated January 2, 20	015 We
	ation you provided on the application and have made the follo	
alisibility datarmination		
engionity determination.		
Name		
DOB	MM/DD/mm	
ID	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	8
Application Status	Denied	
Coverage group	HPE: Pregnant Women group	
Effective Date	January 2, 2015	5
Denial Reason	Excess Income	1
Household size	2	
Countable income	And a set	50
countable income	\$5,800	2
Applicable Income Stand Additional Information: If you completed the DHS	2-25-24	
Applicable Income Stand Additional Information: If you completed the DHS help from the hospital star for regular Medicaid, ever If you are approved, you w the Connector for other at the eligibility determinatio	tard \$2,137 1100 "Application for Health Coverage & Help Paying Costs" v M, it will be sent to the Med-QUEST office to determine your e if your application for HPE assistance was denied. will receive regular Medicaid. If you are denied, you will be ref fordable insurance programs. Med-QUEST will send you a no in for regular Medicaid separately.	eligibility ferred to
Applicable Income Stand Additional Information: If you completed the DHS help from the hospital star for regular Medicaid, ever If you are approved, you w the Connector for other at the eligibility determinatio	tard \$2,137 1100 "Application for Health Coverage & Help Paying Costs" v If, it will be sent to the Med-QUEST office to determine your e if your application for HPE assistance was denied. Will receive regular Medicaid. If you are denied, you will be rel fordable insurance programs. Med-QUEST will send you a no	eligibility ferred to
Applicable Income Stand Additional Information: If you completed the DHS help from the hospital star for regular Medicaid, ever If you are approved, you w the Connector for other at the eligibility determinatio	tard \$2,137 1100 "Application for Health Coverage & Help Paying Costs" v If, it will be sent to the Med-QUEST office to determine your e if your application for HPE assistance was denied. Will receive regular Medicaid. If you are denied, you will be rel fordable insurance programs. Med-QUEST will send you a no in for regular Medicaid separately. and more information contact 1-800-316-8003.	eligibility ferred to
Applicable Income Stand Additional Information: If you completed the DHS help from the hospital stat for regular Medicaid, even if you are approved, you w the Connector for other at the eligibility determination if you have questions or n	tard \$2,137 1100 "Application for Health Coverage & Help Paying Costs" v If, it will be sent to the Med-QUEST office to determine your e if your application for HPE assistance was denied. Will receive regular Medicaid. If you are denied, you will be rel fordable insurance programs. Med-QUEST will send you a no in for regular Medicaid separately. and more information contact 1-800-316-8003.	eligibility ferred to
Applicable Income Stand Additional Information: If you completed the DHS help from the hospital stat for regular Medicaid, even if you are approved, you w the Connector for other at the eligibility determination if you have questions or n	tard \$2,137 1100 "Application for Health Coverage & Help Paying Costs" v If, it will be sent to the Med-QUEST office to determine your e if your application for HPE assistance was denied. Will receive regular Medicaid. If you are denied, you will be rel fordable insurance programs. Med-QUEST will send you a no in for regular Medicaid separately. and more information contact 1-800-316-8003.	eligibility ferred to
Applicable Income Stand Additional Information: If you completed the DHS help from the hospital stat for regular Medicaid, even if you are approved, you w the Connector for other at the eligibility determination if you have questions or n	tard \$2,137 1100 "Application for Health Coverage & Help Paying Costs" v If, it will be sent to the Med-QUEST office to determine your e if your application for HPE assistance was denied. Will receive regular Medicaid. If you are denied, you will be rel fordable insurance programs. Med-QUEST will send you a no in for regular Medicaid separately. and more information contact 1-800-316-8003.	eligibility ferred to
Applicable Income Stand Additional Information: If you completed the DHS help from the hospital stat for regular Medicaid, even if you are approved, you w the Connector for other at the eligibility determination if you have questions or n	tard \$2,137 1100 "Application for Health Coverage & Help Paying Costs" v If, it will be sent to the Med-QUEST office to determine your e if your application for HPE assistance was denied. Will receive regular Medicaid. If you are denied, you will be rel fordable insurance programs. Med-QUEST will send you a no in for regular Medicaid separately. and more information contact 1-800-316-8003.	eligibility ferred to
Applicable Income Stand Additional Information: If you completed the DHS help from the hospital stat for regular Medicaid, even if you are approved, you w the Connector for other at the eligibility determination if you have questions or n	tard \$2,137 1100 "Application for Health Coverage & Help Paying Costs" v If, it will be sent to the Med-QUEST office to determine your e if your application for HPE assistance was denied. Will receive regular Medicaid. If you are denied, you will be rel fordable insurance programs. Med-QUEST will send you a no in for regular Medicaid separately. and more information contact 1-800-316-8003.	eligibility ferred to
Applicable Income Stand Additional Information: If you completed the DHS help from the hospital stat for regular Medicaid, even if you are approved, you w the Connector for other at the eligibility determination if you have questions or n	tard \$2,137 1100 "Application for Health Coverage & Help Paying Costs" v If, it will be sent to the Med-QUEST office to determine your e if your application for HPE assistance was denied. Will receive regular Medicaid. If you are denied, you will be rel fordable insurance programs. Med-QUEST will send you a no in for regular Medicaid separately. and more information contact 1-800-316-8003.	eligibility ferred to
Applicable Income Stand Additional Information: If you completed the DHS help from the hospital stat for regular Medicaid, even if you are approved, you w the Connector for other at the eligibility determination if you have questions or n	tard \$2,137 1100 "Application for Health Coverage & Help Paying Costs" v If, it will be sent to the Med-QUEST office to determine your e if your application for HPE assistance was denied. Will receive regular Medicaid. If you are denied, you will be rel fordable insurance programs. Med-QUEST will send you a no in for regular Medicaid separately. and more information contact 1-800-316-8003.	eligibility ferred to
Applicable Income Stand Additional Information: If you completed the DHS help from the hospital stat for regular Medicaid, even if you are approved, you w the Connector for other at the eligibility determination if you have questions or n	tard \$2,137 1100 "Application for Health Coverage & Help Paying Costs" v If, it will be sent to the Med-QUEST office to determine your e if your application for HPE assistance was denied. Will receive regular Medicaid. If you are denied, you will be rel fordable insurance programs. Med-QUEST will send you a no in for regular Medicaid separately. and more information contact 1-800-316-8003.	eligibility ferred to
Applicable Income Stand Additional Information: If you completed the DHS help from the hospital stat for regular Medicaid, even if you are approved, you w the Connector for other at the eligibility determination if you have questions or n	tard \$2,137 1100 "Application for Health Coverage & Help Paying Costs" v If, it will be sent to the Med-QUEST office to determine your e if your application for HPE assistance was denied. Will receive regular Medicaid. If you are denied, you will be rel fordable insurance programs. Med-QUEST will send you a no in for regular Medicaid separately. and more information contact 1-800-316-8003.	eligibility ferred to
Applicable Income Stand Additional Information: If you completed the DHS help from the hospital stat for regular Medicaid, ever If you are approved, you w the Connector for other at the eligibility determinatio If you have questions or n Authority: H.A.R. 17-1713	tard \$2,137 1100 "Application for Health Coverage & Help Paying Costs" w If, it will be sent to the Med-QUEST office to determine your e if your application for HPE assistance was denied. will receive regular Medicaid. If you are denied, you will be ref fordable insurance programs. Med-QUEST will send you a no on for regular Medicaid separately. seed more information contact 1-800-316-8005. 1.1-30, 17-1714.1-2	rigbility ferred to tice of
Applicable Income Stand Additional Information: If you completed the DHS help from the hospital stat for regular Medicaid, ever If you are approved, you w the Connector for other at the eligibility determination if you have questions or n Authority: H.A.R. 17-1719	tard \$2,137 1100 "Application for Health Coverage & Help Paying Costs" v If, it will be sent to the Med-QUEST office to determine your e if your application for HPE assistance was denied. Will receive regular Medicaid. If you are denied, you will be rel fordable insurance programs. Med-QUEST will send you a no in for regular Medicaid separately. and more information contact 1-800-316-8003.	rigbility ferred to tice of

Attestation Sheet for DHS 1100

	Name of Hospita	d.	
for the Hospital Presumptive	Eligibility (HPE) program. S p the Department to verify	I is meeting Department requ Signing this form is optional. The hospital is in compliance v IPE program.	However,
I certify that Name of	f hospital staff member		
helped me comp Costs form;	lete the DHS 1100 Applicati	on for Health Coverage & Hel	o Paying
Or			
		ication for Health Coverage & t the form, but applicant cho:	
Print name of HPE applicant	. <u></u>		

Sample of Cover Letter

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

Application for Health Coverage & Help Paying Costs

State of Hawai

КИОМ E

0

⊢

THINGS

Department of Human Services

Hawaii Health Connector

 Who can use this application to apply for you or anyone in your family. Apply even if you or your child already has health coverage. You could be eligible for lower-cost or free coverage. 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. If someone is helping you fill out this application, you may need to complete Appendix C. Apply faster online Apply faster online at <u>mybenefits.hawaii.gov</u>. If you want to purchase insurance without help, apply directly at <u>hawaiihealthconnector.com</u> What you may need to apply Social Security Numbers (or document numbers for any legal immigrants who need insurance) Employer and income information for everyone in your family (for example, from paysiubs, W-2 forms, or wage and tax statements) Policy numbers for any current health insurance available to your family Why do we ask for this information? What happens next? 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. Online: mybenefits.hawaii.gov or call 4.977-628-5076 for assistance with completing and submitting an application. Online: mybenefits.hawaii.gov Onli			
 Apply faster online If you want to purchase insurance without help, apply directly at hawaiihealthconnector.com What you may need to apply Social Security Numbers (or document numbers for any legal immigrants who need insurance) Employer and income information for everyone in your family (for example, from paystubs, W-2 forms, or wage and tax statements) Policy numbers for any current health insurance Information about any job-related health insurance available to your family 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'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. What happens next? 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. Get help with this application doesn't mean you have to by health coverage. Online: mybenefits.hawaii.gov Phone: Call the Contact Center at 1-877-628-5076 for assistance with completing and submitting an application. In person: There may be counselors in your area who can help. Visit our wesite or call 1-877-628-5076 for new information. Medicait: For specific questions on Medicaid/CHIP eligibility, call	3		 Apply even if you or your child already has health coverage. You could be eligible for lower-cost or free coverage. 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. If someone is helping you fill out this application, you may need to
 What you may need to apply immigrants who need insurance) Employer and income information for everyone in your family (for example, from payslubs, W-2 forms, or wage and tax statements) Policy numbers for any current health insurance Information about any job-related health insurance Information about any job-related health insurance available to your family 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'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. What happens next? 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. Get help with this application doesn't mean you have to buy health coverage. Online: mybenefits.hawaii.gov Online: Call the Contact Center at 1-877-628-5076 for assistance with completing and submitting an application on the status of your application. In person: There may be counselors in your area who can help. Visit our website or call 1-877-628-5076 for more information. Medicaid: For specific questions on Medicaid/CHIP eligibility, call 		Apply faster online	 If you want to purchase insurance without help, apply directly at
 Why do we ask for this information? Why do we ask for this information? What happens next? 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. Get help with this application Online: mybenefits.hawaii.gov Phone: Call the Contact Center at 1-877-628-5076 for assistance with completing and submitting an application. 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 	D		 immigrants who need insurance) Employer and income information for everyone in your family (for example, from paystubs, W-2 forms, or wage and tax statements) Policy numbers for any current health insurance Information about any job-related health insurance available to your
What happens next? 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 hear from us, visit <u>mybenefits.hawaii.gov</u> or call 1.877-628-5076. Filling out this application doesn't mean you have to buy health coverage. Get help with this application Online: <u>mybenefits.hawaii.gov</u> Phone: Call the Contact Center at 1-877-628-5076 for assistance with completing and submitting an application or getting information on the status of your application. In person: There may be counselors in your area who can help. Visit our website or call 1-877-628-5076 for more information. Medicaid: For specific questions on Medicaid/CHIP eligibility, call)		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
 Get help with this application Phone: Call the Contact Center at 1-877-628-5076 for assistance with completing and submitting an application or getting information on the status of your application. In person: There may be counselors in your area who can help. Visit our website or call 1-877-628-5076 for more information. Medicaid: For specific questions on Medicaid/CHIP eligibility, call 	5		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 hear from us, visit <u>mybenefits.hawaii.gov</u> or call 1-877-628-5076. Filling
	3		 Phone: Call the Contact Center at 1-877-628-5076 for assistance with completing and submitting an application or getting information on the status of your application. In person: There may be counselors in your area who can help. Visit our website or call 1-877-628-5076 for more information. Medicaid: For specific questions on Medicaid/CHIP eligibility, call

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。 Mandarin 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 L 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 1 gh 2014 miles , 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
 Home address (Leave blank if you don't have on 	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 f yes , 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	
(Eve	you need health en if you have ins Yes. If yes, ans	urance, there			ter cove	rage or lower	no, SKIP			estions on ank.	page 3.	0
(Eve	en if you have ins	wer all the q	uestions belo	n twelve (12) monti	nage or lower No. If Le	no, SKIP ave the re Yes	est of th	is page bl			0
(Eve Do) a. [Yes. If you have ins Yes. If yes, ans you have a disa Do you currently Have you receive	wer all the q bility that will receive long ed long term o	last more than term care nursi are nursing ser	n twelve (12 ing services vices in the	!) month : 🔲 Y	No. If No. If Le ns?	no, SKIP ave the re Yes facility	est of th	is page bl	ank.	unity	
(Eve Doy a. (b. H c. (Yes. If you have ins Yes. If yes, ans you have a disa Do you currently	bility that will receive long ed long term o	last more than term care nursi are nursing ser	n twelve (12 ing services vices in the g services n	!) month : 🔲 Y	No. If No. If Le ns?	no, SKIP ave the re Yes facility	No Yes, s. If yes,	is page bl	ank. in the comm	unity	
(Eve Do) a. (b. H c. (d. (you have ins Yes. If yes, ans you have a disa Do you currently Have you receive Do you think you	bility that will receive long ed long term o need long te Supplemental	last more than term care nursi are nursing ser rm care nursing Security Incom	n twelve (12 ing services vices in the g services note (SSN)?	!) month : I Y last thre ow?	rage or lower No. H Le ns? es, in a nursing ee (3) months? Yes Yes	no, SKIP ave the re Yes facility No No No	est of th	is page bl	an k. in the comm ?	unity	
(Eve Do) a. (b. H c. (d. (you have ins Yes. If yes, ans you have a disa Do you currently Have you receive Do you think you Do you receive S	wer all the q bility that will receive long ed long term c u need long te Supplemental medical servic	last more than term care nursi are nursing ser rm care nursing Security Incom	n twelve (12 ing services vices in the g services note (SSN)?	!) month : I Y last thre ow?	rage or lower No. H Le ns? es, in a nursing ee (3) months? Yes Yes	no, SKIP ave the re Yes facility No No No	est of th No Yes, s. If yes, date of t	is page bl	an k. in the comm ?	unity	
(Eve Do) a. [b. k c. [d. [] . Did)	you have ins you have a disa you ourent Do you current Have you receive Do you think you Do you receive s you receive any i	urance, there wer all the q bility that will receive long ed long term c u need long te Supplemental medical servic date(s)?	lest more their term care nursi are nursing ser rm care nursing Security Incom as in the past te	n twelve (12 ing services vices in the g services (SSN)? en (10) calend	!) month : Y ilast three ow? dar day:	rage or lower No. If Le es, in a nursing e (3) months? Yes Yes a immediately	no, SKIP ave the re facility facility No No prior to the	est of th No Yes, s. If yes, date of t	is page bl	an k. in the comm ?	unity	
(Eve Do y a. [b. H c. [d. [] . Did y . Are ;	n if you have ins Yes. If yes, ans you have a diss Do you ourrently Have you ourrective Do you think you Do you receive a you receive any i Yes. If yes, what you a U.S. citize ou aren't a U.S.	urance, there wer all the q bility that will receive long ed long term o u need long te Supplemental medical servic date(s)? en or U.S. nati citizen or U.	uestions belo last more than term care nursing ser rm care nursing ser security Incom security I	n twelve (12 ing services vices in the g services n: the (SSN)? in (10) calent	!) monti : Y i last thre ow? dar day: ip to Qu	rage or lower No. If Le ns? es, in a nursing ee (3) months? Yes s immediately uestion 13.	no, SKIP ave the re facility facility No prior to the No No	est of th No Yes, s. If yes, date of t	is page bl	an k. in the comm ?	unity	
(Eve Do y a. [] b. 8 c. [] d. [] . Did y . Are ; . If yo a. Ir b. D	In if you have ins Yes. If yes, ans you have a diss Do you currently Have you creceiv Do you traceive 3 you receive any i Yes. If yes, what you a U.S. citize su aren't a U.S mmigration doo	urance, there wer all the q bility that will receive long ed long term c u need long term Supplemental medical servic date(s)? en or U.S. nati citizen or U sument type mber	uestions belo last more than term care nursing ser rm care nursing ser security Incom security I	n twelve (12 ing services vices in the g services n: the (SSN)? in (10) calent	!) monti : Y i last thre ow? dar day: ip to Qu	rage or lower No. If Le ns? es, in a nursing ee (3) months? Yes s immediately uestion 13.	no, SKIP ave the re facility facility No prior to the No No	est of th No Yes, s. If yes, date of t	is page bl	an k. in the comm ?	unity	
(Eve Do) a. [b. 8 c. [d. 0 . Did) . Did) . Are a. Ir b. D c. W	In if you have ins Yes. If yes, ans you have a disa to you currently Have you receive Do you receive any in Yes. If yes, what you a U.S. citize bu aren't a U.S. bou aren't a U.S. or occurrent ID nu hen did you entor	urance, there wer all the q billity that will receive long del long term c u need long te Supplemental medical servic date(s)? en or U.S. nati outment type mber the U.S.?	uestions belo last more that term care nursing ser m care nursing. Security Incom es in the past te onal? Yes S. national, pl	a twelve (12 ing services vices in the g services in the (SSN)? in (10) calent s. If yes, ski ease provid	t) month last three ow? dar day: ip to Qu ip to Qu e the in	Interpretation of the second s	no, SKIP sve the ri Yes facility No orior to the No No No ow.	est of th No Yes, s. If yes, date of t	is page bl	in the comm ?	unity	
(Eve Do) a. (b.) c. (d. (l. Did) c. (d. (l. Did) c. (a. Ir b. D c. (w d. Are)	In if you have ins Yes. If yes, ans you have a diss Do you currently Have you creceiv Do you traceive 3 you receive any i Yes. If yes, what you a U.S. citize su aren't a U.S mmigration doo	urance, there wer all the q receive long ed long term c u need long term c supplemental medical servic date(s)? en or U.S. nati . etitzen or U.S. nati . etitzen or U.S. pument type mber er the U.S.?	uestions belo last more than term oare nursing ser moare nursing Security Incom es in the past te onsi? Yes S. national, pl d State of Mior	h twelve (12 ing services in the g services in the g services in the g services in the g services in the g services in the g services in the g services in the g services in the g services in t	2) month ast thre ow? dar day: ip to Qu ip to Qu e the in Republic	rage or lower No. If Comparison of the Marsha	no, SKIP1 ave the re facility facility orior to the No No ow.	est of th No Yes, s. If yes, t date of t	in my home what date(s) his applicat	an k. in the comm ?	unity	
(Eve Doy a. (b. H c. (d. (l. Didy . Are s. Irr b. D c. W d. A e. Are	In if you have ins Yes. If yes, ans Do you currently Have you receive Do you think you Do you think you Do you receive any Yes. If yes, what Yes. If yes, what Yes. If yes, what Yes. It yes, what You a U.S. citize su aren't a U.S mmigration doc hocument ID nu when did you ents re you a ottizen or re you, or you	urance, there wer all the q receive long ded long term c supplemental additional ded date(s)? in or U.S. nati .citizen or U sument type mber ar the U.S.? of the Federate r spouse or p	uestions belo last more that term oare nursing ser nursing ser rm care nursing Security Incom ess in the past te onal? Yes S. national, pl Yes S. national, pl d State of Mior arent, a veter	bw. twelve (12 ing services ing services ing services ing services in the g services in the is (SSN)? in (10) calent is. If yes, ski ease provid consist, the R an or an acc	t) month last thre ow? dar days ip to Qui le the in Republic stive-du	rage or lower No. It Le se, in a nursing (3) months (4) Yes is immediately uestion 13. formation be of the Marsha ty member of	no, SKIP: ave the rr Statistical facility facility facility no orrior to the No No ow.	est of th No Yes, s. If yes, date of t o and Ealar military?	is page bl	in the comm ? ion? Yes	unity	
(Eve Do) a. [b.] c. (d. (. Did) . Are : b. D c. W d. Are : . Are :	In if you have ins Yes. If yes, ans Do you currently Have you receive Do you think you Do you think you Do you receive any Yes. If yes, what Yes. If yes, wha	urance, there wer all the q billity that will receive long and long term or uned long term or uned long term supplemental medical servio date(s)? unment type mber_ r the US.? of the Federate r spouse or p v or one of the	uestions belo last more than term care nursi are nursing server in a server security Income ses in the past te onal? Yes S. national, pl uestion of Micro arent, a veter e primary pers	by: the velve (12 ing services in the g services in the g services in the g services in the services i	() month last three ow? dar days ip to Qu le the in cepublic tive-du care o	rage or lower No. It Le ses, in a nursing (3) Months (4) Yes is immediately uestion 13. formation be of the Marsha ty member of f a child under	no, SKIP: ave the rr Statistical facility facility facility no orrior to the No No ow.	est of th No Yes, s. If yes, date of t o and Ealar military?	is page bl	in the comm ? ion? Yes	I No No	No
(Eve Do y a. [] b. H c. (d. [] d. [] . Are . Are b. D c. W d. Are . Are . Are . Wer	In if you have ins Yes. If yes, ans Do you currently Have you receive Do you thick you Do you thick you Do you receive any i Yes. If yes, what you a U.S. citize you a U.S. citize you a U.S. citize to a U.S. citize you a citizen i re you, or you you the primary e you in foster or	urance, there we rall the q bility that will receive long and long term or uned long term or uned long term date(s)? mor U.S. nati- citizen or U.S. nati- citizen or U.S. nati- citizen or U.S. rati- citizen or U.S. rati- of the Federatus s pouse or p or or one of th- mer at age 18 c	uestions belo last more than terre nursing series are nursing series security income as in the past te conal? Yes S. national, pl d State of Micro arent, a veter a primary pers r older in Hawa	by: the velve (12 ing services in the g services in the g services in the g services in the services i	() month last three ow? dar days ip to Qu le the in cepublic tive-du care o	rage or lower No. It Le ses, in a nursing (3) Months (4) Yes is immediately uestion 13. formation be of the Marsha ty member of f a child under	no, SKIP: ave the rr Statistical facility facility facility no orrior to the No No ow.	est of th No Yes, s. If yes, date of t o and Ealar military?	is page bl	in the comm ? ion? Yes	I No No	No
(Even Do y a. [b.] c. [d. [l. Did y c. Market b. Did y c. Warket c. Warket c. Warket c. Warket c. Warket c. Warket c. Market c. Mark	In if you have ins Yes. If yes, ans you have a disa Do you currently Have you receive Do you think you Do you receive any i Yes. If yes, what you a U.S. citize you aren't a U.S mmigration doo bocument ID nu /then did you entor re you, or you you the primary e you in foster or you a full-time st	urance, there we rall the q bility that will receive long doing term or uned long term or uned long term date(s)? mor U.S. nati- citizen or U.S. nati- citizen or U.S. nati- citizen or U.S. of the Federatis s pouse or r or or one of th- mer at age 18 c uddet?	uestions belo last more than term oare nursing ser mr care nursing security locomas in the past te security locomas as in the past te conal? Yes S. national, pl d State of Micro arent, a veter a primary pers r older in Hawa Yes No	 by O b twelve (12 ing services rivices in the g services rivices in the (SSN)? b. If yes, ski sease provid c. If yes, s	2) month last three ow? dar days dar days ip to Qu e the in Republic stive-du p care o N	rage or lower No. It Le ses, in a nursing (3) Months (4) Yes is immediately uestion 13. formation be of the Marsha ty member of f a child under	no, SKIP: ave the rr Statistical facility facility facility no orrior to the No No ow.	est of th No Yes, s. If yes, date of t o and Ealar military?	is page bl	in the comm ? ion? Yes	I No No	No
(Even (Even) Doy s. (I b. H c. (I d. (I) Didy 1. Are c. Wen c. Wen i. Are k. Are t. Are t. Hyon d. A c. Wen i. Are t. Hyon d. Hyonn d. Hyon d. Hyonn d. Hyonn Hyonn d. Hyonn Hyonn d. Hyonn Hyonn Hyonn Hyonn Hyonn	In if you have ins Yes. If yes, ans Do you currently Have you receive Do you think you Do you think you Do you think you Do you receive (you receive (you receive) (you a U.S. citize you a to you migration doo you a to you you the primary e you a full-time st ispanio/Latino, e	urance, there we rall the q bility that will receive long doing term or uned long term or uned long term date(s)? mor U.S. nati- citizen or U.S. nati- citizen or U.S. nati- citizen or U.S. of the Federatis s pouse or r or or one of th- mer at age 18 c uddet?	uestions belo last more than term care nursing ren nursing security income as in the past te security income s. national, pl scatter of Micri arent, a veter a primary pers otder in Hawa Yes IN 00 DNAL—oheck a	 by O b twelve (12 ing services rivices in the g services rivices in the (SSN)? b. If yes, ski sease provid c. If yes, s	1) month last three ow? dar days ip to Qu ip to Qu e the in Republic q care o n n .)	rage or lower No. It Le ses, in a nursing (3) Months (4) Yes is immediately uestion 13. formation be of the Marsha ty member of f a child under	no, SKIP: ave the rr Statistical facility facility facility no orrior to the No No ow.	est of th No Yes, s. If yes, 1 date of t o and Rala military? years tha	is page bl	in the comm ?	I No No	No
(Even (Even a. (Construction) (Const	In if you have ins Yes. If yes, ans Do you currently Have you receive Do you think you Do you think you Do you think you Do you receive (you receive (you receive) (you a U.S. citize you a to you migration doo you a to you you the primary e you a full-time st ispanio/Latino, e	urance, there we rall the q billity that will receive long dong term or need long term or supplemental supplemental settics? otizen or U sument type mber or the Setars r spouse or p or one of the reat set 10 undent ? of the Federats r spouse or p or one of the reat set 10 undent? or	uestions belo last more that are nursing ser are nursing ser are nursing ser are nursing Security income as in the past te security income as in the past te consol? Yes S. national, pl schematic sprimary pers or discriment, a veter a primary pers or discriment, a veter s primary pers or discriment, a veter s no No No No No No		1) month last three ow? dar days ip to Qu ip to Qu e the in Republic q care o n n .)	rage or lower No. It Le es, in a nursing es,	no, SKIP ave the re facility facility No No orior to the No ow.	est of th No Yes, s. If yes, 1 date of t o and Rala military? years tha	is page bi	in the comm ?	I No No	No
(Even (Even) Do y a. (b. H c. (d. C 1. Did y b. D c. W d. Are e. Are b. Are c. Wern b. D c. W d. A Are c. Are b. H b. C c. W d. A Are c. Are c. Wern b. D c. W d. A Are c. Are	In if you have ins Yes. If yes, ans you have a disa Do you currently Have you receive Do you think you Do you think you Do you think you Do you receive () you receive () Yes. If yes, what you a U.S. citize you a U.S. citize you a U.S. citize users t a U.S. citize our area to the second migration doo you a U.S. citize users t a U.S. citize you a U.S. citize users t a U	urance, there wer all the q billity that will receive long ed long term ca supplemental medical servic date(s)? un or U.S. nati- citizen or U sument type mber r the U.S.? of the Federatus s pouse or p r or one of the receive at age 18 c dudent? thickity (OPTI) Mexican.Am check all that a is Black or V	uestions belo last more than term oare nursing security laceware as in the past te S. national, pl d. S. nat	W. O h twelve (12) ing services in the g services in the e (SSN)? in (10) calent is, If yes, ski ease provid onesia, the F onesia, the F onesia, the F an or an ac on(s) taking ii? Yes all that apply Chicano/a n	2) month = Y Y last three ow? dar days dar days ip to Qu e the in Republic Q care o N P F F F	rage or lower rage or lower IN0. It Le s. in a nursing es, in a nursing es, in a nursing is immediately estion 13. formation be of the Marsha ty member of f a child unde o uerto Ricen liipino	no, SKIP / ave the r yes facility yes No orior to the No ow. Il Islands, a the U.S. r age 10 y Cut	and Eala military? years tha	in my home what date(s) his applicat his applicat t lives with O the Guam	ank. in the comm ? ion? Yes Yes an you? anian or Chri	I No No Yes	No
(Ever (Ever Do) a. (b.) c. (d. () d. ())))))))))))))))))))))))))))))))))))	n if you have ins Yes. If yes, ans Do you currently Have you receive Do you think you Do you think you Do you treceive si you receive any i Yes. If yes, what you a U.S. citize you aren't a U.S mmigration doo ourant ID nu then did you enth re you, or you you the primary e you in foster or you a full-time st ispanio/Latino, e (OPTIONAL -	urance, there wer all the q billity that will receive long ed long term ca supplemental medical servic date(s)? un or U.S. nati- citizen or U sument type mber r the U.S.? of the Federatus s pouse or p r or one of the receive at age 18 c dudent? thickity (OPTI) Mexican.Am check all that a is Black or V	uestions belo last more than term care nursing ser are nursing ser are nursing ser ser nursing security income ses in the past te security income ses in the past te conal? Yes S. national, pl di State of Micri arent, a veter a primary pers or older in Hawa Yes No DNAL—ohock & cricean U C oppply). Microan America	W. O h twelve (12) ing services in the g services in the e (SSN)? in (10) calent is, If yes, ski ease provid onesia, the F onesia, the F onesia, the F an or an ac on(s) taking ii? Yes all that apply Chicano/a n	2) month = Y Y last three ow? dar days dar days ip to Qu e the in Republic Q care o N P F F F	rage or lower rage or lower INO. It Le ss, in a nursing e (3) months? Yes is immediately uestion 13. formation be of the Marsha ty member of f a child unde o uerto Rican liipino [paparese []	no, SKIP ave the re Yes facility Yes No Orior to the No No ow. Il Islands, a the U.S. r age 19 y	And Ealar and Ealar military? ban ban ban ban ban	in my home what date(s) his applicat his applicat t lives with O the Guam	in the comm ? ion? Yes Yes an you? anian or Cha	I No No Yes	No

••• 🛧

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 13-007-MM7	all we need to know a make a copy of STEP 2: PEF	RSON 2 (Pages 4 and 5) and Complete Approval Date
s If there is 2 or TN NC NEED HELP WI	more people to include, please in the second	all we need to know a make a copy of STEP 2: PEF	RSON 2 (Pages 4 and 5) and Complete

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 material stands or Pla	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.) Yes. If yes, please answer questions a=o. No. If no, skip to question c. Will PERSON 2 file jointly with a spouse? Yes No. If yes, name of spouse: Will PERSON 2 be claimed as a dependent on someone's tax return? Yes No If yes, list name(s) of dependents: 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? How is PERSON 2 need health coverage? (Even if they have insurance, three might be a program with better coverage or lower costs.) Yes. 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. Does PERSON 2 need health coverage? (Even if they have insurance, three might be a program with better coverage or lower costs.) Yes. 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. Does PERSON 2 needved long term care nursing services: Yes. If yes, what date(s)? Des PERSON 2 needved long term care nursing services: Yes. If yes, what date(s)? Des PERSON 2 needved Supplemental Security Income (S3)? Yes in No Des PERSON 2 acetaits or the past ten		me address as you?	Yes 🗌	No					
a. Will PERSON 2 file jointly with a spouse? Yes No If yes, name of spouse:				tax return	n.)				
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									_
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. If no, SKIP to the income questions on page 5. Leave the rest of this page blank. 10. Does PERSON 2 have a disability that will last more than twelve (12) months? Yes No a. Does PERSON 2 currently receive long term care nursing services: Yes, in anusing facility (12) Yes, in my home in the community b. Has PERSON 2 need long term care nursing services in the last three (3) months? 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? No 12. Is PERSON 2 are U.S. national? Yes. If yes, skip to Question 14. No 13. If PERSON 2 and the primary person(s) taking oare of a child under age 19 years that lives with you? Yes No 14. Is PERSON 2 a clitter of the primary person(s) taking oare of a child under age 19 years that lives with you? Yes No 15. Wes PERSON 2 are the years at a setive of Micronesia, the Republic of the Marshall Islands or Palau? Yes No 14. Is PERSON 2 a ther the U.S.? In Mo Is PERSON 2 a clitter of the primary pers			e's tax return? 📘	Yes	L No				
8. Is PERSON 2 pregnant? Yes No Myes, 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. If no, SKIP to the income questions on page 5. Leave the rest of this page blank. 10. Does PERSON 2 have a disability that will last more than twelve (12) months? Yes. If yes, in my home in the community 10. Does PERSON 2 currently receive long term care nursing services: Yes, in a nursing 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. in my home in the community 11. Did PERSON 2 receive any medical services in the past ten (10) calendar days immediately prior to the date of this application? 12. Is PERSON 2 a u.S. citizen or U.S. national? Yes. H yes, skip to Question 14. 13. If PERSON 2 enter the U.S.? 0. Unoment ID number 0. Use PERSON 2 enter the U.S.? 14. Is PERSON 2 enter the U.S.? 15. Was PERSON 2 need to gitern or an active-duty member of the U.S. military? 14. Is PERSON 2 enter the U.S.? 15. Was PERSON 2 isn't a victure 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.? 14. Is PERSON 2 the primary or one of the primary person(s) taking oare of a child under age 19 years that lives with you? 15. Was PERSON 2 in forts care at age 18 or older in Hawaii? 16. Is PERSON 2 in folser care at age 18 or older in Hawaii?	If yes, please list the nar	ne of the tax filer:							
9. Does PERSON 2 need health coverage? (Even if they have insurance, there might be a program with better coverage or lower costs.) Yes. If yes, answer all the questions below. ID. Does PERSON 2 have a disability that will last more than twelve (12) months? ID. Does PERSON 2 need long term care nursing services: ID. Does PERSON 2 need long term care nursing services: ID. Does PERSON 2 need long term care nursing services in the last three (3) months? ID. Does PERSON 2 need long term care nursing services in the last three (3) months? ID. Does PERSON 2 need long term care nursing services in the last three (3) months? ID. Does PERSON 2 need long term care nursing services in the last three (3) months? ID. Does PERSON 2 need long term care nursing services in the last term (10) calendar days immediately prior to the date of this application? ID. Did PERSON 2 are U.S. national? IV es. If yes. what date(s)? ID. Does PERSON 2 and U.S. national? IV es. If yes. and the 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 nother spouse or parent, a veteran or an active-duty member of the U.S. military? IS PERSON 2 in their spouse or parent, a veteran or an active duty member of the U.S. military? IS. BERSON 2 in their spouse or parent, a veteran or an active-duty member of the U.S. military? IS. Was PERSON 2 in forter care at age 18 or older in Hawaii? IS. Was PERSON 2 in forter care at age 18 or older in Hawaii? IS. Nos IS. Race (OPTIONAL - check all that ap	How is PERSON 2 relate	d to the tax filer?							
(Even if they have insurance, there might be a program with better coverage or lower costs.) Ves. If yes, answer all the questions below. No. If no, SKIP to the income questions on page 5. Lawe the rest of this page blank. Does PERSON 2 have a disability that will last more than twelve (12) months? Does PERSON 2 nearently receive long term care nursing services: Yes, in a nursing tailoity (Yes, in my home in the community) Has PERSON 2 nearently macer nursing services in the last three (3) months? Does PERSON 2 nearently are care nursing services in the last three (3) months? Does PERSON 2 nearently are care nursing services in the last three (3) months? Does PERSON 2 nearently are care nursing services in the last three (3) months? Does PERSON 2 nearently any medical services in the past ten (10) calendar days immediately prior to the date of this application? Yes. If yes, what date(s)? Solow 2 nearently is a U.S. citizen or U.S. national? Use PERSON 2 a U.S. citizen or U.S. national? Does PERSON 2 ender the U.S.? Document ID number Docum	8. Is PERSON 2 pregnant?	Yes 🔲 No 🌿 yes, how m	nany babies are e	pected d	uring this preg	nancy?	Expected	Due Date _	_
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.)				
Leave the rest of this page blank. Leave the rest of the rest of the rederated State of Micronesia, the Republic of the Marshall Islands or Palsu? Les PERSON 2 on the rederated State of Micronesia, the Republic of the Marshall Islands or Palsu? Les PERSON 2 in foster care at age 18 or older in Hawaii? Les PERSON 2 in foster care at age 18 or older in Hawaii? Les PERSON 2 in			· · ·		,	income	questions or	nage 5	
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 constraint, a veteran or an active-duty member of the U.S. military? Societary Yes No Ls PERSON 2 in forter care at age 18 or older in Hawaii? Yes No Societary Constraints, ethnicity (OPTIONAL—check all that apply.) Mexican Mexican American (Chicano/a Puerto Rican Cuban Other	_	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
Yes. If yes, what date(s)? No 12. Is PERSON 2 a U.S. otizen or U.S. national? Yes. If yes, skip to Question 14. No 13. If PERSON 2 is n't a U.S. otizen or U.S. national, please provide the information below. a. Imagingtion document type. b. Document ID number c. When did PERSON 2 a otizen of the Federated State of Micronesia, the Republic of the Marshall Islands or Palau? Yes No 14. Is PERSON 2 in of the Federated State of Micronesia, the Republic of the U.S. military? Yes No 14. Is PERSON 2 in their spouse or parent, a veteran or an active-duty member of the U.S. military? Yes No 14. Is PERSON 2 in other one of the primary person(s) taking care of a child under age 19 years that lives with you? Yes No 15. Was PERSON 2 in forster care at age 13 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 American American Chicano/a Puerto Rican Cluban Other White Black or African American Chicano/a Plapenese Other Asian Indian American Indian or Alaska Native Asian Indian American Indian or Alaska Native Asian Indian American Indian or Alaska Native Korean Samoan Other Asian Other Now, tell us about any income from PERSON 2 on the back									
12. Is PERSON 2 a U.S. otizen or U.S. national? Yes. If yes, skip to Question 14. No 13. If PERSON 2 isn't a U.S. otizen or U.S. national. please provide the information below. a. Immigration document type			n (10) calendar da			e date of ti	his application?	?	
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	
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 Hispanio/Latino, ethnicity (OPTIONAL—oheck all that apply.) Mexican Mexican,American Chicano/a Puerto Rican Cluban Other 18. Race (OPTIONAL—oheck all that apply.) White Black or African American Merican Japanese Other Asian Indian American Indian or Alaska Native Japanese Other Asian Other Pacific Islander Chinese Now, tell us about any income from PERSON 2 on the back						i Falau :			
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 Hispanic/Latino, ethnicity (OPTIONAL—check all that apply.) Mexican Mexican American Chicano/a Puerto Rican Cluban Other 18. Race (OPTIONAL—check all that apply.) White Black or African American American American Indian or Alaska Native Japanese Other Asian Other Admines Other Pacific Islander Chinese Netwe Hawaiian Korean Samoan Other Now, tell us about any income from PERSON 2 on the back	14. Is PERSON 2 the primary or	one of the primary person(s) to	aking care of a chi	ld under a	oe 19 vears th	at lives with	vou?	Yes [n.
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 Cuban Other 18. Race (OPTIONAL—check all that apply.) White Black or African American American Indian or Alaska Native Adian Indian American Indian or Alaska Native Guamanian or Chamorro Chinese Now, tell us about any income from PERSON 2 on the back				-	a- ·- / ··				-
17. If Hispanio/Latino, ethnicity (OPTIONAL—oheck all that apply.) Mexican Mexican, American Chicano/a Puerto Rican Race (OPTIONAL - check all that apply.) White Black or African American Asian Indian American American Chinese Other African American Korean Samoan Other Other				1 40					_
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.)							_
Chinese Native Hawaiian Korean Samoan Other Now, tell us about any income from PERSON 2 on the back									
Now, tell us about any income from PERSON 2 on the back				_		_		nder	
	Chinese Nat		_	_		_			
		Now, te	ll us about	any ind	come froi	n PER	SON 2 on	the bac	K.
	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

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 🗌

Г

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.

	л	~
- 2	1	h

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	he plan is no less than 60 percent of such costs (Section

47

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			 Employer Identification Number (EIN)
5. Employer address (notice will be sent to this a	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
 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: Per capite payments from a tribe that come from natural resources, usage rights, leases, or royalties. 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). Money from selling things that have cultural significance. 	\$ 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 applicat	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)	
matters with this agency. 10. Your signature	11. Da	mation about this application, and act for you on all future ate (mm/dd/ggg)	
matters with this agency. 10. Your signature Authorized Represent As the designated Authoriz Department or tts designe	11. Da	ite (mm/dd/1999)	
matters with this agency. 10. Your signature Authorized Represent As the designated Authoriz Department or it's designe	11. Da ative ced Representative, I agree to maintain the confi e and I can be released as the Authorized Repre	identiality of any information provided to me by the esentative by signing below: Telephone Date City State Zip Code	
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 informe	11. Dr ative ted Representative, I agree to maintain the configeration of 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 R tion and the prohibition against reassignme on the facility's behalf, as well other relevan	identiality of any information provided to me by the esentiality by signing below: Telephone Date	
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	11. Dr ative ted Representative, I agree to maintain the configeration of 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 R tion and the prohibition against reassignme on the facility's behalf, as well other relevan		
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 configeration of a configuration of a configuration of a configuration of a configuration of serving as the Authorized Representative PRINT Name of Individual PRINT Name of Provider/Organization as a condition of serving as the Authorized Representation and the prohibition against reassignme or on the facility's behalf, as well other relevar pration. In counselors, navigators, agents, and I 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. Dr 11. Dr 21		

TN NO: 13-007-MM7

х

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

2 CFR 435.110 902(a)(10)(A)(931(b) and (d)	(i)(I) ×	
	d Other Caretaker Relatives - Parents adard established by the state.	and other caretaker relatives of dependent children with household income at c
The stat	e attests that it operates this eligibility g	roup in accordance with the following provisions:
🗐 Ine	dividuals qualifying under this eligibilit	y group must meet the following criteria:
	Are parents or other caretaker relative (defined at 42 CFR 435.4) under age	es (defined at 42 CFR 435.4), including pregnant women, of dependent childre 18. Spouses of parents and other caretaker relatives are also included.
	The state elects the following options	이 집에 가지 않는 것 같은 것 같은 것 같이 있는 것 같이 많이 많이 많이 많이 많이 많이 많이 없다.
		lividuals who are parents or other caretakers of children who are 18 years old, e students in a secondary school or the equivalent level of vocational or
	Options relating to the definition	of caretaker relative (select any that apply):
	The definition of caretaker re- even after the partnership is to	ative includes the domestic partner of the parent or other caretaker relative, erminated.
	Definition of domestic partner:	
	The definition of caretaker re half-blood), adoption or marr	ative includes other relatives of the child based on blood (including those of iage.
	Description of other relatives:	
	The definition of caretaker re primary responsibility for the	ative includes any adult with whom the child is living and who assumes dependent child's care.
	Options relating to the definition	of dependent child (select the one that applies):
	The state elects to eliminate it care by reason of the death, p least one parent.	he requirement that a dependent child must be deprived of parental support or hysical or mental incapacity, or absence from the home or unemployment of a
	O The child must be deprived of unemployment of the parent (f parental support or care, but a less restrictive standard is used to measure select the one that anglies).

Medicaid Eligibility
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 Standard
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 ar other caretaker relatives to MAGI-equivalent standards and the determination of the maximum income standard 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.
• 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.
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 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:

-9 H

	A percentage of the federal poverty level: 100 %
	 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.
	O Other dollar amount
	Income standard chosen:
	Indicate the state's income standard used for this eligibility group:
1	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.
	O Another income standard in-between the minimum and maximum standards allowed
	There is no resource test for this eligibility group.
1	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.
	O Yes No

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 S25-3



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

42 CFR 435.116 1902(a)(10)(A)(i)(III) and (I	
1902(a)(10)(A)(ii)(I), (IV) a	
1931(b) and (d)	
1920	
Pregnant Women - Wo	nen who are pregnant or post-partum, with household income at or below a standard established by the state
The state attests that	it operates this eligibility group in accordance with the following provisions:
Individuals qua	ifying under this eligibility group must be pregnant or post-partum, as defined in 42 CFR 435.4.
group in accord	n in the last trimester of their pregnancy without dependent children are eligible for full benefits under this ance with section 1931 of the Act, if they meet the income standard for state plan Parents and Other ives at 42 CFR 435.110.
O Yes 💿	No
	come methodologies are used in calculating household income. Please refer as necessary to S10 MAGI-Base ologies, completed by the state.
Income standard	used for this group
🔳 Minimum i	ncome standard (Once entered and approved by CMS, the minimum income standard cannot be changed.)
	ad an income standard higher than 133% FPL established as of December 19, 1989 for determining or pregnant women, 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 i	ncome standard
✓ women	te certifies that it has submitted and received approval for its converted income standard(s) for pregnant to MAGI-equivalent standards and the determination of the maximum income standard to be used for it women under this eligibility group.
	and the second
The state's	maximum income standard for this eligibility group is:
familia C (A)(ii) (institu	te's highest effective income level for coverage of pregnant women under sections 1931 (low-income s), 1902(a)(10)(A)(i)(III) (qualified pregnant women), 1902(a)(10)(A)(i)(IV) (mandatory poverty level-pregnant women), 1902(a)(10)(A)(ii)(IX) (optional poverty level-related pregnant women), 1902(a)(10)(A)(ii)(IV) (pregnant women who meet AFDC financial eligibility criteria) and 1902(a)(10)(A)(ii)(IV) tionalized pregnant women) in effect under the Medicaid state plan as of March 23, 2010, converted to a equivalent percent of FPL.

?

	Medicaid Eligibility
	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)(I) (pregnant women who meet AFDC financial eligibility criteria) and 1902(a)(10)(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.
	O 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.
2	O 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.
	O 185% FPL
	The amount of the maximum income standard is: 191 % FPL
] Income standard chosen
	Indicate the state's income standard used for this eligibility group:
	O The minimum income standard
3 1 1	• The maximum income standard
	O Another income standard in-between the minimum and maximum standards allowed.
Th	ere is no resource test for this eligibility group.
Be	nefits for individuals in this eligibility group consist of the following:
C	All pregnant women eligible under this group receive full Medicaid coverage under this state plan.
С	Pregnant women whose income exceeds the income limit specified below for full coverage of pregnant women receive only pregnancy-related services.
Pre	sumptive Eligibility
	e state covers ambulatory prenatal care for individuals under this group when determined presumptively eligible by a alified entity.
C	Yes 💿 No

PRA Disclosure Statement



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

and the second)(i)(III), (IV), (VI) and (VII))(ii)(IV) and (IX)	
	d Children under Age 19 - Infants and children under age 19 with household income at or below standards establish sed on age group.	ned by
🖌 The	ate attests that it operates this eligibility group in accordance with the following provisions:	
	bildren 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.	
	AGI-based income methodologies are used in calculating household income. Please refer as necessary to S10 MAG ased Income Methodologies, completed by the state.	i l-
	ncome 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 under age one to MAGI-equivalent standards and the determination of the maximum income standard to be u for infants under age one.	
	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-inc 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 MAG equivalent percent of FPL.	

Approval Date: 09/13/2013 S30-1



			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
		1	MAGI-equivalent percent of FPL.
		0	The state's effective income level for any population of infants under age one under a Medicaid 1115
		0	demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.
		~	The state's effective income level for any population of infants under age one under a Medicaid 1115
		0	demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.
•		0	185% FPL
		Ente	er the amount of the maximum income standard: 191 % FPL
		Inco	me 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
			nfants) 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
			nfants) 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
			f 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.
		1	f higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and
		O i	f 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.
			승규는 방법은 것을 잘 들었다. 이는 것을 알려야 한다. 것은 것을 알고 있는 것을 하는 것을 수가 없다. 것을 하는 것을 하는 것을 하는 것을 하는 것을 하는 것을 수가 없다. 말하는 것을 하는 것을 수가 없는 것을 수가 없는 것을 수가 없다. 말하는 것을 하는 것을 수가 없는 것을 수가 없는 것을 수가 없는 것을 수가 없다. 것을 수가 없는 것을 수가 없는 것을 수가 없는 것을 수가 없는 것을 수가 없다. 말하는 것을 수가 없는 것을 수가 없는 것을 수가 없는 것을 수가 없는 것을 수가 없다. 것을 수가 없는 것을 수가 없다. 것을 수가 없는 것을 수가 없는 것을 수가 없는 것을 수가 없다. 것을 수가 없는 것을 수가 없는 것을 수가 없는 것을 수가 없다. 것을 수가 없는 것을 수가 없는 것을 수가 없는 것을 수가 없다. 않는 것을 것을 것을 수가 없는 것을 수가 없는 것을 수가 없는 것을 수가 없다. 것을 수가 없는 것을 수가 없는 것을 수가 없는 것을 수가 없는 것을 수가 없다. 것을 것을 것을 수가 없는 것을 수가 없는 것을 수가 없는 것을 수가 없다. 것을 것을 것을 것을 수가 없는 것을 수가 없는 것을 수가 없는 것을 수가 없다. 것을 것을 것을 것을 수가 없는 것을 수가 없는 것을 수가 없는 것을 수가 없다. 않는 것을 것을 것을 것을 수가 없는 것을 것을 수가 없다. 것을 것을 것을 것을 수가 없는 것을 것을 것을 수가 없다. 것을 것을 것을 것을 것을 것을 것을 것을 수가 없다. 않는 것을 것을 것을 것을 것을 것을 것을 것을 것을 수가 없다. 않는 것을
		0	Another income standard in-between the minimum and maximum standards allowed, provided it is higher than
		I	he effective income standard for this age group in the state plan as of March 23, 2010.
	Inco	ome s	tandard for children age one through age five, inclusive
		Mini	mum income standard

S	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 b 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.
	 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 December 31, 2013, 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 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 childre 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, and 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)(III) (IV) (institutionalized children), in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.



		0	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.
		0	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.
		0	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.
1	🔳 In	come	standard for children age six through age eighteen, inclusive
		Mi	nimum income standard
		Th	e minimum income standard used for this age group is 133% FPL.
		Ma	iximum income standard
		Ø	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	e state's maximum income standard for children age six through eighteen is:
		0	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 $1902(a)(10)(A)(i)(IV)$ (institutionalized children), in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.
		0	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 $1902(a)(10)(A)(i)(IV)$ (institutionalized children), 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 children age six through eighteen 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 children age six through eighteen under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.
		۲	133% FPL
		Inc	ome standard chosen
			e state's income standard used for children age six through eighteen 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 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.

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.

• Yes O No

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.

O Yes O No

TN No: 13-0007-MM1 Hawaii Effective Date: 1/01/2014



PRA Disclosure Statement



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

4

2 CFR 435 902(a)(10)	
	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	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 ONo
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.
0	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

I 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 \$25 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.



The state's effective income level for any population of parents/caretaker relatives under a Medicaid 1115 (e) 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: 200

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.

%

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.

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, 01996, converted to a MAGI-equivalent standard. If this standard has not been completed in S14 AFDC

^JIncome 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 %

O Other dollar amount

There is no resource test for this eligibility group.

Effective Date: 10/01/2013



PRA Disclosure Statement

.



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 💿 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 O 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(f) - Like Children	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

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 O 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).

O 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

42 CFR 435.227	
1902(a)(10)(A)(ii)(VIII	D

Children with Non IV-E Adaption Assistance - The state elects to cover children with special needs for whom there is a non IV-E adoption assistance agreement in effect with a state, who were eligible for Medicaid, or who had income at or below a standard established by the state and in accordance with provisions described at 42 CFR 435.227.

• 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 meet the following criteria:

The state adoption agency has determined that they cannot be placed without Medicaid coverage because of special needs for medical or rehabilitative care;

Are under the following age (see the Guidance for restrictions on the selection of an age):

- Under age 21
- O Under age 20
- O Under age 19
- O Under age 18

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 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 also covered this eligibility group in the Medicaid state plan as of March 23, 2010.

• Yes O No

Individuals qualify under this eligibility group if they were eligible under the state's approved state plan prior to the execution of the adoption agreement.

The state used an income standard or disregarded all income for this eligibility group either in the Medicaid state plan as of March 23, 2010 or December 31, 2013, or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013.

O Yes O No

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.

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.

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.

in the second second

The state's maximum income standard for this classification of children (which must exceed the minimum for the classification) is:

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.

O 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

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.

O 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.

🔿 Yes 💿 No

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 Hawali Approval Date: 09/13/2013 \$55-1



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 O 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

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 Approval Date: 09/13/2013 \$59-1

ATTACOUNTY 2

MI: converted thresholds date: 09-APR-2013

population/type	applicant type	citiation	size	original standard		
Family - 1988	applicant	APDC 5/1/1988	1	\$327	\$493	
1911 - H			2 .	\$430	\$653	
			3	\$515	\$795	
			4	\$501	\$938	
			5	\$689	\$1,083	
			6	\$780	\$1,232	
			7	\$882	\$1,391	
			8		\$1,508	
			9	\$1,000	81,623	
	and the second second		10	\$1,059	\$1,739	
- in the second s			11	\$1,119 '	\$1,857	
		and the second sec	12	\$1,179	\$1,974	
			13	\$1,239	\$2,091	
			14	\$1,299	\$2,208	
			15	\$1,359	\$2,325	
			addon	\$60	\$110	
	ben 4 months	AFDC 5/1/1988	1	\$327	\$397	
			2	\$430	\$524	
and the state of the	and the second second		3	\$515	\$633	
the second second second second			4	\$601	\$744	
the second second second	and the second s		5	\$689	\$856	
And the second se			6	\$780	\$971	
the second se			7	\$882	\$1,097	
			8	\$942	\$1,181	
tenne tententen og			9	\$1,000	\$1,263	
and the supervised states and the supervised states and the supervised states and the supervised states and the			10	\$1,059	\$1,347	
			11	\$1,119	\$1,431	
			12	\$1,179	\$1,515	
the second states and a			13	\$1,239	\$1,599	
	-		14	\$1,299	\$1,683	
			15	\$1,359	\$1,767	
			addon.	\$60	\$81	
	ben 8 months	AFDC 5/1/1988	1	\$327	\$388	
AND THE REAL PROPERTY OF A PARTY OF			2	\$430	\$512	
······································		the second s	3	\$515	\$618	
**************************************			4	\$601	\$725 \$634	
and the second second second			5	\$689 \$780	\$947	
and the second sec			7	4883	\$1,070	
			8	\$942	\$1,151	
and the second s			9		\$1,230	
			10	\$1,000	\$1,310	
and the second s	and the second s		11	\$1,119	\$1,391	
the second se	interesting and a second se		12	\$1,179	\$1,472	
			13	\$1,239	\$1,553	
			14	\$1,299	\$1,634	
			15	\$1,359	\$1,715	
			addon	\$60	\$78	
amily - 1996	annligent	APDC 7/16/1996	1	\$418	\$630	
amity - 1990	applicant	MEDC //10/1998	2	\$565	\$851	
	and a strategic and and	- provide	3	8712	\$1,071	
			4	\$859	\$1,291	
			5	\$1,006	\$1,511	
			6	\$1,153	\$1,732	
and the second second second			7	\$1,300	\$1,952	
the state of the s			8	\$1,446	\$2,171	
and the second s			9	\$1,593	\$2,392	
All and a second se			10	\$1,740	\$2,612	
all to all			11	\$1,887	\$2,832	
the state of the second st			12	\$2,034	\$3,052	
			13	\$2,181	\$3,273	
the second se		the second second	14	\$2,328	\$3,493	
And the second		1 4 4 F	15	\$2,475	\$3,713	
and share the second		A CONTRACTOR OF A	addon	8146	\$210	
A COMPANY AND A COMPANY A CO	ben 4 months	AFDC 7/16/1996	11	\$418	\$479	
and the second s		· ·	2	\$565	\$647	
		and the second se	1-	14444	14.4.8.1	

TN No: 13-0007-MM1 Hawaii Approval Date: 09/13/2013 Attachment 2-1

Effective Date: 1/01/2014

TN No:	13-0007-MM1
Hawali	

Approval Date: 09/13/2013 Attachment 2-2 ŧ

	T		4	6859	\$983
	T		5	\$1,006	\$1,151
			6	81,153	\$1,319
34			7	\$1,300	\$1,487
		-	B	\$1,446	81,654
			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
		the second s	15	\$2,475	\$2,831
			addon	\$146	\$164
	ben 6 months	AFDC 7/16/1996	1	\$418	8469
· · · · · · · · · · · · · · · · · · ·	area o anatemo	Arte 1/10/1330	2	\$565	\$634
			3	8712	\$799
			4	6859	6964
			5	\$1,005	\$1,129
			6	\$1,153	\$1,293
			7	\$1,300	161,458
	<u> </u>		8		and the second distance of the second state of the second state of the second state of the second state of the
				\$1,446	\$1,622
and the second			9	\$1,593	
· · · · · · · · · · · · · · · · · · ·			10	\$1,740	\$1,951
			11	\$1,887	\$2,116
· The second sec			12	\$2,034	\$2,281
			13	\$2,181	\$2,446
			14	\$2,328	\$2,610
			15 addon	\$2,475	\$2,775
		1902 (a) (10) (A) (i) (IV) mandatory powerty- level related pregnant women			
regnant and children <1		covered for pregnancy-related services and mandatory poverty- level related infan		185% FPL	1914 <i>FPL</i>
bild 1-5		1902 (a) (10) (A) (i) (VI) mandatory poverty- level related children aged 1-5		1338 FPL	139 % PP L
Thild 6-18		1902 (a) (10) (A) (i) (VI I) mandatory poverty level related children aged 6-18		100% FPL	105% FPL
Mult 19-64	The second se	1115		200% FPL	208% FPL
Thildren <19 (>150/133/100%)		M-CHIP children <19 1902(a)(10)(A)(ii)(X IV)		300% FFL	3088 FFL

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				
MAGI-Based In	come	Me	thodol	ogies	s		

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 §435.603(f)(2)(i) as a tax dependent.

(Yes (No

OMB Control Number: 0938-1148

Expiration date: 10/31/2014

S10



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

USE OF THE ALTERNATIVE SINGLE STREAMLINED APPLICATION					
TRANSMITTAL NUMBER:	STATE:				
INNOMITING NOMBER.	SIALD.				
13-0008-MM	Hawaii				
Through Maugh 21 2014 the state is usid					
Through March 31, 2014, the state is using an interim online alternative single streamlined application. After March 31, 2014, the state will use a revised online alternative single streamlined application, which will address the issues outlined in the CMS letter dated October 1, 2014 concerning the state's application. The revised application will be incorporated by reference into the state plan.					

· · ·

Г

....

٦

.



Medicaid Eligibility

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



Medicaid Eligibility

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.



Medicaid Eligibility

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

TN No: 16-0001 Supercedes TN No: 14-0008 Approval Date: 04/03/2017 Online Application -1

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	Visa Number	
Document Description		
Citizenship Certificate Number	Citizenship Certificate Number	
Naturalization Certificate Numbe	Naturalization Certificate Number	
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
5 *		
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 ?
•		v
	Income Start Date	Income End Date
		Remove
Learner Trees	A	
Income Type	Amount(\$)	How Often ?
	•	_
	Income Start Date	Income End Date

Add more income type

TN No: 16-0001 Supercedes TN No: 14-0008 Approval Date: 04/03/2017 Online Application -5

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 =	_

Approval Date: 04/03/2017 Online Application -7

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 *	
	-		-	
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	· •
•		• • -		
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	
	-				
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? *	•		
F 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	tName *	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/

Online Application -17

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

Approval Date: 04/03/2017 Online Application -22

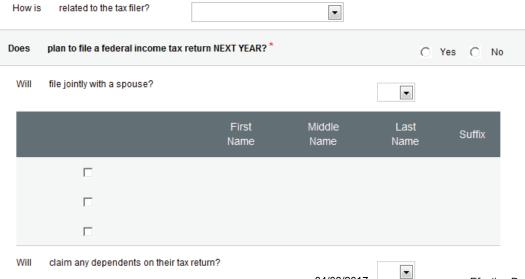
Tax Dependents

Answer these questions for everyone applying for help paying for health insurance.

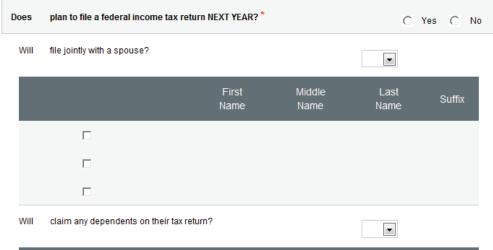
If you indicated tax relationships to other people, but do not see them on this page, please go back to Household Details to add them to this application.

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	1 .	

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	mber	
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	a A		
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		12.0	
			Remove 0	
Is enrolled in health coverag	e now?"		0	Yes C No
s enrolled in health coverag	e now?*		C	Yes C 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	
-				

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 or Alaskan Native Family Member (Al/AN)			
American Indian or 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	No. No one in my family is American Indian or Alaskan Native.		
Yes. If yes, answer the	ollowing questions.		
Is an American Indian or	laskan Native?*	C Yes C No	
Is a member of a Federally r	cognized Tribe ? *		
○ Yes ○ No			
If 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. *	r 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	ghts, leases, or royalties	
	resources, farming, ranching, fishing, leases, or roya		
	t of Interior (including reservations and former reserva	ations)	
 Money from selling this 	ngs that have cultural significance		
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

THINGS TO KNOW	3	Use this application to see what coverage choices you qualify for	 Affordable private health insurance plans that offer comprehensive coverage to help you stay well. A new tax credit that can immediately help pay your premiums for health coverage. Free or low-cost insurance from Medicaid or the Children's Health Insurance Program (CHIP).
	&	Who can use this application?	 Use this application to apply for you or anyone in your family. Apply even if you or your child already have health coverage. You could be eligible for lower-cost or free coverage. 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. If someone is helping you fill out this application, you may need to complete Appendix C.
		Apply faster online	 Apply faster online at <u>mybenefits.hawaii.gov</u>. If you want to purchase insurance without help, apply directly at <u>www.healthcare.gov</u>.
	B	What you may need to apply	 Social Security Numbers (or document numbers for any legal immigrants who need insurance). Employer and income information for everyone in your family (for example, from pay stubs, W-2 forms, or wage and tax statements). Policy numbers for any current health insurance. Information about any job-related health insurance available to your family.
	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	 Online: <u>mybenefits.hawaii.gov</u> 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. 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. Medicaid: For specific questions on Medicaid/CHIP eligibility, call 1-800-316-8005 (TTY/TDD 1-800-603-1201).

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 1-877-628-5076 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 1-877-628-5076 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 1-877-628-5076 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 1-877-628-5076 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 1-877-628-5076 `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 1-877-628-5076 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 1-877-628-5076 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 1-877-628-5076 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 1-877-628-5076 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 1-877-628-5076 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 1-877-628-5076 '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 1-877-628-5076 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 1-877-628-5076 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	rst name Middle name		Last name	Last name	
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.	4. City		5. State	6. ZIP code	7. County	
8.	Mailing address (if different from home add	dress)	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 Email address:	application by email?	? 🗌 Yes	🗌 No		
17	17. What is your preferred spoken language (if not English)?			is your preferred written langu	uage (if not English)?	
19	. How many family members live with you?		jailed)	family member you usually li or residing in the Hawaii Stat s No , please list their name(s):	e Hospital?	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. Rel SE	ationship to PER LF	RSON 1?
3.	Date of birth (mm/dd/yyyy)			4. Gender:	Male Female		Name of s	pouse if married	-
6.	Social Security Number (SS	SN)							
	We need this if you want he up the application process. W help getting an SSN, call 1-80	Ve use SSNs to check i	ncome and other infor	mation to see who is	s eligible	for help with h			
7.	Do you plan to file a feder (You can still apply for healt	th insurance even if y	ou do not file a federa	_	,				
	 Yes. If yes, please a a. Will you file jointly with a 	· _	_	No. If no, sk	ip to qu	uestion c.			
	If yes, write name of sp	. —							
	 b. Will you claim any deperimental dependence of the second se	,	turn? 🗌 Yes	No					
	 Will you be claimed as If yes, write the name of How are you related to 	of the tax filer:	one's tax return?	Yes N	lo 				
8.	Are you pregnant? Ye		ow many babies are	expected during th	nis pregn	ancy? I	Expected [Due Date:	
9.	Do you need health covera			□ No. If no,	SKIP to	-	questions	· · · · · · · · · · · · · · · · · · ·	•
10.	Do you have a disability t		_	ths? 🗌 Yes	C	No			
	 a. Do you currently received. b. Have you received lon 	ng term care nursing	-	-		☐ Yes, in my ☐ No	home in th	e community	🗌 No
	c. Do you think you nee	0	0	? 🗌 Yes		□ No □ No			
11.	d. Do you receive Supp Did you receive any medica				r to the c		oplication?		
	Yes. If yes, what date(s)?				No			
	Are you a U.S. citizen or U.		es. If yes, skip to Qu			No			
	. If you are not a U.S. citize nmigration document type (i.		Status type (option					gration documer	
Δ	lien or I-94 number			Passnort nu	mber or	other card nu	umber		
				Fassport nu			Inner		
S	EVIS ID or Expiration Date (optional)		Other (cate	gory code	e or country o	of issuance	2)	
14.	Provide the date of entry								
	a. Are you a citizen of th	e 🗌 Federated Sta	tes of Micronesia,	Republic of M	larshall	Islands, or	Republ	ic of Palau?	
_	b. Are you, your spouse o	r parent, a veteran or	an active-duty mem	per of the U.S. mili	tary?	🗌 Yes	🗌 No		
15.	Were you in foster care at a	age 18 years or older	in Hawaii? 🗌 Ye	s 🗌 No					
16.	Are you a full-time student?	Yes 🗌	No						
17.	If Hispanic/Latino, ethnicity	` _		rto Rican 🔲 (Cuban	Other_			
18.	Race (OPTIONAL : mark al	11.37				\ <i>(</i> ; _ t =		0	
		Black or African Amer		Filipino	=	Vietnamese		Guamanian or C	
	Asian Indian	American Indian or Al Native Hawaiian	asna ivalive	Japanese	_	Other Asian Samoan		Other Pacific Isla Other:	
?		IR APPLICATION?		waii.gov or call us	s at 1-87	7-628-5076.		ed help in a lang	
	you. TTY/TDD users sl			-	-				
υŀ	IS 1100 (REV. 12/16) TN No: 16-0001		App	roval Date: 04/03	/2017			P	age 2 of 9

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	 How much net income (p from this self-employments) 		
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	v 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 No , what date(s)? No
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 No	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 Yes No b. Is PERSON 2, PERSON 2' Was PERSON 2 in foster care	f the Federates spouse or parer	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 (O 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.			If-employed ip 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:			 b. How much net income (pro PERSON 2 get from this se \$	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	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):								
Household Member PERSON 3								
Name of Person 3:	Relationship to Person 1:	Relationship to Person 2:						
Is Person 3 primarily responsible for the care of a child(ren) under age 19 years old in this household? Yes, name of 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 the care of a		🗌 Yes, name	of child(ren):	
child(ren) under age 19 years old in this	□ 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 Me	dicare						
If it is an employer insurance: (You will also need to complete Appendix A.)	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	
 13. Are you currently eligible for coverage offered by thi Yes (continue) 	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:
No (STOP 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
 16. What change will the employer make for the new year (if known)? Employer will not 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
*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/d	d/yyyy	(conti	nue)				
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	ployee's spouse or dep pendent(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 wellness programs, provide the premium that the emp and did not receive any other discounts based on well	loyee would pay if he/sh								
a. How much would the employee have to pay in pren									
b. How often? Weekly Every 2 weeks		nce a month 🗌 Qua	rterly	ΠY	early				
 16. What change will the employer make for the new yea Employer will not offer health coverage. Employer will start offering health coverage to emmeets the minimum value standard. *(Premium sa. How much will the employee have to pay in pro- 	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	 Yes If yes, tribe name is: No
3. Has this person ever gotten a service from the Indian Health Service, a tribal health program, urban Indian health program, or through a referral from one of these programs?	 Yes No If no, is this person eligible to get 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 If no, is this person eligible to get services from the Indian Health services, tribal health programs, urban Indian health programs, or through a referral from one of these programs?
		🗌 Yes 🔲 No
 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: 	\$ How often?	\$ How often?
 Per capita payments from a tribe that come from natural resources, usage rights, leases, or royalties. 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 		
Money from selling things that have cultural significance.		



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.

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:

ty , am a pro	State vider or staff mer	ZIP Code
, am a pro	vider or staff mer	nber or volunteer
f provider claims a State and Federal	s appropriate fo	or a health facility
kers only		
ker filling out this appli	cation for someone	else.
	4. ID number (if applicable)
	f provider claims a t State and Federal kers only	esentative, I will adhere to the regul f provider claims as appropriate fo t State and Federal laws covering of kers only ker filling out this application for someone 4. ID number (

12. Date (mm/dd/yyyy)

rans. no. 74. Sapprovel: 2/27/

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; **B.** 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. 11 No. Yes, as described below:

Revision: HCFA-AT-80-58 August, 1980

Attachment 2.6-C Page 6

State of HAWAII

2.

- 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:

DHEW Trans. No.	MCAS	80-18
	Dec YY	1980
Trans. Date DHEW Approval .	FER	091931