State: Hawaii

Agency*	Citation(s)	Groups Covered
		A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)
		2. Deemed Recipients of AFDC
	1902 (a)(10)(A)(I)(I) of the Act	b. Effective October 1, 1990, participants in a work supplementation program under title IV-A and any child or relative of such individual (or other individual living in the same household as such individuals) who would be eligible for AFDC if there were no work supplementation program, in accordance with section 482 (e)(6) of the Act.
	402 (a)(22)(A) of the Act	c. Individuals whose AFDC payment are reduced to zero by reason of recovery of overpayment of AFDC funds.
	406(h) and 1902(a)(10)(A)(I)(I) of the Act	d. An assistance unit deemed to be receiving AFDC for a period of four calendar months because the family becomes ineligible for AFDC as a result of collection or increased collection of support and meets the requirements of section 406(h) of the Act.
	1902(a) of the Act	e. Individuals deemed to be receiving AFDC who meet the requirements of section 473(b)(1) or (2) for whom an adoption assistance agreement is in effect or foster care maintenance payments are being made under title IV-E of the Act.

* See Supplement 15 to Attachment 2.6-A for eligibility under section 1931 of the Act.

* Agency that determines eligibility for coverage.

Agency*	Citation(s)	Groups Covered
		A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)
	407(b), 1902 (a)(10)(A)(i) and 1905(m)(1) of the Act	3. Qualified Family Members Effective October 1, 1990, qualified family members who would be eligible to receive AFDC under section 407 of the Act because the principal wage earner is unemployed. /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.)

*Agency that determines eligibility for coverage.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: HAWAII

COVERAGE AND CONDITIONS OF ELIGIBILITY

Citation(s)	Groups Covered
	A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)
1902(a)(10)(A)(i)(V) and 1905(m) of the Act	~~10.~~ Individuals other than qualified pregnant women and children under item A.7. above who are members of a family that would be receiving AFDC under section 407 of the Act if the State had not exercised the option under section 407(b)(2)(B)(i) of the Act to limit the number o months for which a family may receive AFDC.
Duplicates item A.3 on page 2a, per MRM 92-10.	
1902(e)(5) of the Act	11. a. A woman who, while pregnant, was eligible for, applied for, and receives Medicaid unde the approved State plan on the day her pregnancy ends. The woman continues to be eligible, as though she were pregnant, for all pregnancy-related and postpartum medical assistance under the plan for a 60-day perio (beginning on the last day of her pregnancy) and for any remaining days in the month in which the 60th day falls.
1902(e)(6) of the Act	b. A pregnant woman who would otherwise lose eligibility because of an increase in income (of the family in which she is a member) during the pregnancy or the postpartum perio which extends through the end of the month i which the 60-day period (beginning on the last day of pregnancy) ends.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: HAWAII

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

*Agency that determines eligibility for coverage.

State: _____

Agency*	Citation(s)	Groups Covered

A. Mandatory Coverage – Categorically Needy and Other Required Special Groups (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

✓ Blind

✓ 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 ATTACHMENT 2.6-A).

*Agency that determines eligibility for coverage.

State: HAWAII

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

*Agency that determines eligibility for coverage.

State: HAWAII

Agency*	Citation(s)	Groups Covered

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

(4) Be seriously inhibited by the lack of Medicaid coverage in their ability to continue to work or obtain employment; and

(5) Have earnings that are not sufficient to provide for himself or herself a reasonable equivalent of the Medicaid, SSI (including any Federally administered SSP), or public funded attendant services that would be available if he or she did have such earnings.

☐ Not applicable with respect to individuals receiving only SSP because the State either does not make SSP payments or does not provide Medicaid to SSP–only recipients.

*Agency that determines eligibility for coverage.

Agency*	Citation(s)		Groups Covered
		A.	Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)
	1619(b)(3) of the Act	/X/	The State applies more restrictive eligibility requirements for Medicaid than under SSI and under 42 CFR 435.121. Individuals who qualify for benefits under section 1619(a) of the Act or individuals described above who meet the eligibility requirements for SSI benefits under section 1619(b)(1) of the Act and who met the State's more restrictive requirements in the month before the month they qualified for SSI under section 1619(a) or met the requirements of section 1619(b)(1) of the Act are covered. Eligibility for these individuals continues as long as they continue to qualify for benefits under section 1619(a) of the Act or meet the SSI requirements under section 1619(b)(1) of the Act.

*Agency that determines eligibility for coverage.

Agency*	Citation(s)	Groups Covered
		A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)
	1634(c) of the Act	15. Except in States that apply more restrictive eligibility requirements for Medicaid than under SSI, blind or disabled individuals who--
		a. Are at least 18 years of age;
		b. Lose SSI eligibility because they become entitled to OASDI child's benefits under section 202(d) of the Act or an increase in these benefits based on their disability. Medicaid eligibility for these individuals continues for as long as they would be eligible for SSI, absent their OASDI eligibility.
		/X/ c. The State applies more restrictive eligibility requirements than those under SSI, and part or all of the amount of the OASDI benefit that caused SSI/SSP ineligibility and subsequent increases are deducted when determining the amount of countable income for categorically needy eligibility.
		/_/ d. The State applies more restrictive requirements than those under SSI, and none of the OASDI benefit is deducted in determining the amount of countable income for categorically needy eligibility.
	42 CFR 435.122	16. Except in States that apply more restrictive eligibility requirements for Medicaid than under SSI, individuals who are ineligible for SSI or optional State supplements (if the agency provides Medicaid under §435.230), because of requirements that do not apply under title XIX of the Act.
	42 CFR 435.130	17. Individuals receiving mandatory State supplement

*Agency that determines eligibility for coverage.

Agency*	Citation(s)	Groups Covered

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

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.

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

X Aged X Blind X Disabled

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

*Agency that determines eligibility for coverage.

Agency*	Citation(s)	Groups Covered
		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, they--
		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 disability criteria; and
		b. Were eligible for Medicaid in December 1973 as blind or disabled; and
		c. For each consecutive month after December 1973 continue to meet December 1973 eligibility criteria.

*Agency that determines eligibility for coverage.

Agency*	Citation(s)	Groups Covered

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

42 CFR 435.134

21. Individuals who would be SSI/SSP eligible except for the increase in OASDI benefits under Pub. L. 92-336 (July 1, 1972), who were entitled to OASDI in August 1972, and who were receiving cash assistance in August 1972.

[ ] Includes persons who would have been eligible for cash assistance but had not applied in August 1972 (this group was included in this State's August 1972 plan).

[ ] Includes persons who would have been eligible for cash assistance in August 1972 if not in a medical institution or intermediate care facility (this group was included in this State's August 1972 plan).

[X] Not applicable with respect to intermediate care facilities; the State did or does not cover this service.

*Agency that determines eligibility for coverage.

Agency*	Citation(s)	Groups Covered

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

42 CFR 435.135 22. Individuals who --

a. Are receiving OASDI and were receiving SSI/SSI but became ineligible for SSI/SSP after April 1977; and

b. Would still be eligible for SSI or SSP if cost-of-living increases in OASDI paid under section 215(i) 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.

/_/ Not applicable because the State applies more restrictive eligibility requirements than those under SSI.

/X/ 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 t amount of countable income for categorica needy eligibility.

*Agency that determines eligibility for coverage.

Agency*	Citation(s)	Groups Covered

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

1634 of the Act

23. Disabled widows and widowers who would be eligible for SSI or SSP except for the increase in their OASDI benefits as a result of the elimination of the reduction factor required by section 134 of Pub. L. 98-21 and who are deemed, for purposes of title XIX, to be SSI beneficiaries or SSP beneficiaries for individuals who would be eligible for SSP only, under section 1634(b) of the Act.

[ ] Not applicable with respect to individuals receiving only SSP because the State either does not make these payments or does not provide Medicaid to SSP-only recipients.

[X] The State applies more restrictive eligibility standards than those under SSI and considers these individuals to have income equalling the SSI Federal benefit rate, or the SSP benefit rate for individuals who would be eligible for SSP only, when determining countable income for Medicaid categorically needy eligibility.

*Agency that determines eligibility for coverage.

State/Territory: HAWAII

Agency*	Citation(s)	Groups Covered
	1634(d) of the Act	A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

24. Disabled widows, disabled widowers, and disabl unmarried divorced spouses who had been marrie to the insured individual for a period of at least ten years before the divorce became effective, who have attained the age of 50, whc are receiving title II payments, and who becaus of the receipt of title II income lost eligibility for SSI or SSP which they received in the month prior to the month in which they began to receive title II payments, who would b eligible for SSI or SSP if the amount of the title II benefit were not counted as income, an who are not entitled to Medicare Part A.

___ The State applies more restrictive eligibility requirements for its blind o disabled than those of the SSI program.

_X_ In determining eligibility as categorically needy, the State disregard the amount of the title II benefits identified in § 1634(d)(1)(A) in determining the income of the individual but does not disregard any more of this income than would reduce the individual' income to the SSI income standard.

___ In determining eligibility as categorically needy, the State disregard only part of the amount of the benefits identified in §1634(d)(1)(A) in determining the income of the individual which amount would not reduce the individual's income below the SSI income standard. The amount of these benefits to disregarded is specified in Supplemen 4 to Attachment 2.6-A.

___ In determining eligibility as categorically needy, the State chooses not to deduct any of the benefit identified in § 1634(d)(1)(A) in determining the income of the individual

*Agency that determines eligibility for coverage.

State: Hawaii

Agency* Citation(s)	Groups Covered
	A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)
1902(a)(10)(E)(i), 1905(p) and 1860D-14(a)(3)(D) of the Act	25. Qualified Medicare beneficiaries – 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 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 this plan)
1902(a)(10)(E)(ii) and 1905(s) of the Act	26. Qualified disabled and working individuals -- 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 of the Act.)

*Agency that determines eligibility for coverage.

State: Hawaii

Agency* Citation(s)	Groups Covered
	A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)
1902(a)(10)(E)(iii), 1905(p)(3)(A)(ii), and 1860D-14(a)(3)(D) of the Act	27. Specified low-income Medicare beneficiaries - - 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 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) and 1905(p)(3)(A)(ii) and 1860D-14(a)(3)(D) of the Act	28. Qualifying individuals -- 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.

*Agency that determines eligibility for coverage.

State: Hawaii

Agency*	Citation(s)	Groups Covered
		A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)
	1634(e) of the Act	29. a. 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.
		X 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.

Agency*	Citation(s)	Groups Covered

B. Optional Groups Other Than the Medically Needy

42 CFR 435.210 1902(a)(10)(A)(ii) and 1905(a) of the Act

/X/ 1. Individuals described below who meet the income and resource requirements of AFDC, SSI, or an optional State supplement as specified in 42 CFR 435.230, but who do not receive cash assistance.

/ / The plan covers all individuals as described above.

/X/ The plan covers only the following group or groups of individuals:

- X Aged
- X Blind
- X Disabled
- X Caretaker relatives
- X Pregnant women

42 CFR 435.211

/X/ 2. Individuals who would be eligible for AFDC, SSI or an optional State supplement as specified in 42 CFR 435.230, if they were not in a medical institution.

*Agency that determines eligibility for coverage.

State: HAWAII

Agency*	Citation(s)	Groups Covered

B. Optional Groups Other Than the Medically Needy (Continued)

42 CFR 435.212 & 1902(e)(2) of the Act, P.L. 99-272 (section 9517) P.L. 101-508 (section 4732)

___ 3. The State deems as eligible those individuals who became otherwise ineligible for Medicaid while enrolled in an HMO qualified under Title XIII of the Public Health Service Act, or a managed care organization (MCO), or a primary care case management (PCCM) program, but who have been enrolled in the entity for less than the minimum enrollment period listed below. Coverage under this section is limited to MCO or PCCM services and family planning services described in section 1905(a)(4)(C) of the Act.

X The State elects not to guarantee eligibility.

___ The State elects to guarantee eligibility. The minimum enrollment period is ____ months (not to exceed six).

The State measures the minimum enrollment period from:

[ ] The date beginning the period of enrollment in the MCO or PCCM, without any intervening disenrollment, regardless of Medicaid eligibility.

[ ] The date beginning the period of enrollment in the MCO or PCCM as a Medicaid patient (including periods when payment is made under this section), without any intervening disenrollment.

[ ] The date beginning the last period of enrollment in the MCO or PCCM as a Medicaid patient (not including periods when payment is made under this section) without any intervening disenrollment or periods of enrollment as a privately paying patient. (A new minimum enrollment period begins each time the individual becomes Medicaid eligible other than under this section).

* Agency that determines eligibility for coverage.

State: HAWAII

Agency*	Citation(s)	Groups Covered

1932(a)(4) of the Act B. Optional Groups Other Than the Medically Needy (Continued)

The Medicaid Agency may elect to restrict the disenrollment of Medicaid enrollees of MCOs, PIHPs, PAHPs, and PCCMs in accordance with the regulations at 42 CFR 438.56. This requirement applies unless a recipient can demonstrate good cause for disenrolling or if he/she moves out of the entity's service area or becomes ineligible.

X Disenrollment rights are restricted for a period of 12 months (not to exceed 12 months).

During the first three months of each enrollment period the recipient may disenroll without cause. The State will provide notification, at least once per year, to recipients enrolled with such organization of their right to and restrictions of terminating such enrollment.

___ No restrictions upon disenrollment rights.

1903(m)(2)(H), 1902(a)(52) of the Act
P.L. 101-508
42 CFR 438.56(g)

In the case of individuals who have become ineligible for Medicaid for the brief period described in section 1903(m)(2)(H) and who sere enrolled with an MCO, PIHP, PAHP, or PCCM when they became ineligible, the Medicaid agency may elect to reenroll those individuals in the same entity if that entity still has a contract.

X The agency elects to provide automatic reenrollment of the above individuals into the same entity if they were disenrolled solely because of loss of Medicaid eligibility for a period of 2 months or less.

___ The agency elects not to reenroll above individuals into the same entity in which they were previously enrolled.

* Agency that determines eligibility for coverage.

Agency*	Citation(s)	Groups Covered

B. Optional Groups Other Than the Medically Needy
(Continued)

42 CFR 435.217 [X]

4. A group or groups of individuals who would be eligible for Medicaid under the plan if they were in a NF or an ICF/MR, who but for the provision of home and community-based services under a waiver granted under 42 CFR Part 441, Subpart G would require institutionalization, and who will receive home and community-based services under the waiver. The group or groups covered are listed in the waiver request. This option is effective on the effective date of the State's section 1915(c) waiver under which this group(s) is covered. In the event an existing 1915(c) waiver is amended to cover this group(s), this option is effective on the effective date of the amendment.

Agency*	Citation(s)	Groups Covered

B. Optional Groups Other Than the Medically Needy (Continued)

1902(a)(10)(A)(ii)(VII) of the Act

[X] 5. Individuals who would be eligible for Medicaid under the plan if they were in a medical institution, who are terminally ill, and who receive hospice care in accordance with a voluntary election described in section 1905(o) of the Act.

[X] The State covers all individuals as described above.

[ ] The State covers only the following group or groups of individuals:

___ Aged
___ Blind
___ Disabled
___ Individuals under the age of--
___ 21
___ 20
___ 19
___ 18
___ Caretaker relatives
___ Pregnant women

*Agency that determines eligibility for coverage.

Agency* Citation(s) Groups Covered

B. Optional Groups Other Than the Medically Needy (Continued)

42 CFR 435.230 ☐ 10. States using SSI criteria with agreements under sections 1616 and 1634 of the Act.

- The following groups of individuals who receive only a State supplementary payment (but no SSI payment) under an approved optional State supplementary payment program that meets the following conditions. The supplement is--

a. Based on need and paid in cash on a regular basis.

b. Equal to the difference between the individual's countable income and the income standard used to determine eligibility for the supplement.

c. Available to all individuals in the State.

d. Paid to one or more of the classifications of individuals listed below, who would be eligible for SSI except for the level of their income.

___ (1) All aged individuals.

___ (2) All blind individuals.

___ (3) All disabled individuals.

Agency*	Citation(s)	Groups Covered

B. Optional Groups Other Than the Medically Needy (Continued)

	___	(4)	Aged individuals in domiciliary facilities or other group living arrangements as defined under SSI.
42 CFR 435.230	- ___	(5)	Blind individuals in domiciliary facilities or other group living arrangements as defined under SSI.
	___	(6)	Disabled individuals in domiciliary facilities or other group living arrangements as defined under SSI.
	___	(7)	Individuals receiving a Federally administered optional State supplement that meets the conditions specified 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:

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 ATTACHMENT 2.6-A.

Agency*	Citation(s)	Groups Covered

B. Optional Groups Other Than the Medically Needy (Continued)

42 CFR 435.121 and 435.230 1902(a)(10)(A)(ii)(XI) of the ACt

/X/ 11. Section 1902(f) States and SSI criteria States without agreements under section 1616 or 1634 of the Act.

The following groups of individuals who receive a State supplementary payment under an approved optional State supplementary payment program that meets the following conditions. The supplement is--

a. Based on need and paid in cash on a regular basis.

b. Equal to the difference between the individual's countable income and the income standard used to determine eligibility for the supplement.

c. Available to all individuals in each classification and available on a Statewide basis.

d. Paid to one or more of the classifications of individuals listed below:

___ (1) All aged individuals.

___ (2) All blind individuals.

___ (3) All disabled individuals.

Agency* Citation(s) Groups Covered

B. Optional Groups Other Than the Medically Needy (Continued)

X	(4)	Aged individuals in domiciliary facilities or other group living arrangements as defined under SSI.
X	(5)	Blind individuals in domiciliary facilities or other group living arrangements as defined under SSI.
X	(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:

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

_X_ No

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

Agency*	Citation(s)	Groups Covered

B. Optional Groups Other Than the Medically Needy (Continued)

42 CFR 435.231 ☑
1902(a)(10)(A)(ii)(V) of the Act

12. Individuals who are in institutions for at least 30 consecutive days and who are eligible under a special income level. Eligibility begins on the first day of the 30-day period. These individuals meet the income standards specified in Supplement 1 to ATTACHMENT 2.6-A.

☑ The State covers all individuals as described above.

☑ The State covers only the following group or groups of individuals:

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

___ Aged
___ Blind
___ Disabled
___ Individuals under the age of--
  ___ 21
  ___ 20
  ___ 19
  ___ 18
___ Caretaker relatives
___ Pregnant women

Agency*	Citation(s)		Groups Covered
			B. Optional Groups Other Than the Medically Needy (Continued)
1902(e)(3) of the Act	/7/	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 2.2-A describes th method that is used to determine the cost effectiveness of caring for this group of disabled children at home.
1902(a)(10)(A)(ii)(IX) and 1902(l) of the Act	/X/	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 Supplement to ATTACHMENT 2.6-A for a family of the same size, including the woman and unborn child or infant and who meet the resource standards specified in Supplement 2 to ATTACHMENT 2.6-A:
		a.	Women during pregnancy (and during the 60-day period beginning on the last day of pregnancy); and
		b.	Infants under one year of age.

Agency*	Citation(s)	Groups Covered

B. Optional Groups Other Than the Medically Needy (Continued)

1902(a)(ii)(X) and 1902(m)(1) and (3) of the Act	/X/	16. Individuals-- a. Who are 65 years of age or older or are disabled, as determined under section 1614(a)(3) of the Act. Both aged and disabled individuals are covered under this eligibility group. b. Whose income does not exceed the income level (established at an amount up to 100 percent of the Federal income poverty level) specified in Supplement 1 to ATTACHMENT 2.6-A for a family of the same size; and c. Whose resources do not exceed the maximum amount allowed under SSI; under the State's more restrictive financial criteria; or under the State's medically needy program as specified in ATTACHMENT 2.6-A.

State/Territory: HAWAII

Citation	Groups Covered
	B. Optional Coverage Other Than the Medically Needy (Continued)
1906 of the Act	18. Individuals required to enroll in cost-effective employer-based group health plans remain eligible for a minimum enrollment period of _____ months.
1902(a)(10)(F) and 1902(u)(1) of the Act	19. 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 pvoerty 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.

State: HAWAII

	_____		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.
1920A ~~1902A~~ 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.

State: HAWAII

Citation(s)		Groups Covered
		B. Optional Coverage Other Than the Medically Needy (Continued)
1902(a)(10)(A) and 1920 of the Act	X	23. Women who:
		a. have been screened for breast or cervical cancer under the Centers for Disease Control 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.
1920B of the Act	___	24. Women who are determined by a "qualified entity" (as defined in 1920B (b) based on preliminary information, to be a woman described in 1902 (aa) of the Act related to certain breast and cervical cancer patients. The presumptive period begins on the day that the determination is made. The period ends on the date that the State makes a determination with respect to the woman's eligibility for Medicaid, or if the woman does not apply for Medicaid (or a Medicaid application was not made on her 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 that last day.

Agency*	Citation(s)	Groups Covered

C. Optional Coverage of the Medically Needy

42 CFR 435.301 — This plan includes the medically needy.

[ ] No.

[X] Yes. This plan covers:

1. Pregnant women who, except for income and/or resources, would be eligible as categorically needy under title XIX of the Act.

1902(e) of the Act — 2. Women who, while pregnant, were eligible for and have applied for Medicaid and receive Medicaid as medically needy under the approved State plan on the date the pregnancy ends. These women continue to be eligible, as thou they were pregnant, for all pregnancy-related and postpartum services under the plan for a 60-day period, beginning with the date the pregnancy ends, and any remaining days in the month in which the 60 day falls.

1902(a)(10)(C)(ii)(I) of the Act — 3. Individuals under age 18 who, but for income and/or resources, would be eligible under section 1902(a)(10)(A)(i) of the Act.

Agency*	Citation(s)	Groups Covered

C. Optional Coverage of Medically Needy (Continued)

1902(e)(4) of the Act

4. Newborn children born on or after October 1, 1984 to a woman who is eligible as medically needy and is receiving Medicaid on the date of the child's birth. The child is deemed to have applied and been found eligible for Medicaid on the date of birth and remains eligible for one year so long as the woman remains eligible and the child is a member of the woman's household.

42 CFR 435.308

5. /_/ a. Financially eligible individuals who are not described in section C.3. above and who are under the age of--

___ 21
___ 20
___ 19
___ 18 or under age 19 who are full-time students in a secondary school or in the equivalent level of vocational or technical training

/X/ b. Reasonable classifications of financially eligible individuals under the ages of 21, 20, 19, or 18 as specified below:

X (1) Individuals for whom public agencies are assuming full or partial financial responsibility and who are:

X (a) In foster homes (and are under the age of 21).

X (b) In private institutions (and are under the age of 21).

Agency*	Citation(s)	Groups Covered

C. Optional Coverage of Medically Needy (Continued)

X (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).

X (2) Individuals in adoptions subsidized in full or part by a public agency (who are under the age of 21).

X (3) Individuals in NFs (who are under the age of 19). NF services are provided under this plan.

X (4) In addition to the group under (b)(3), individuals in ICFs/MR (who are under the age of 19).

X (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.

X (6) Other defined groups (and ages), as specified in Supplement 1 of ATTACHMENT 2.2-A.

State: Hawaii

Agency *	Citation(s)	Group Covered
		C. Optional Coverage of Medically Needy (continued)
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.
42 C.F.R. 435.326		11. Blind and disabled individuals who: a. Meet all current requirements for Medicaid eligibility except the blindness or disability criteria; b. Were eligible as medically needy in December 1973 as blind or disabled; and c. For each consecutive month after December 1973 continue to meet the December 1973 eligibility criteria.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: HAWAII

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

Agency	Citation(s)	Groups Covered
	1935(a) and 1902(a)(66) 42 CFR 423.774 and 423.904	The agency provides for making Medicare prescription drug Low Income Subsidy determinations under Section 1935(a) of the Social Security Act. 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; 3. 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.

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)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

~~XXXXXXXXX~~ State: HAWAII

A. DEFINITION OF BLINDNESS IN TERMS OF OPHTHALMIC 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.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: HAWAII

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

Not Applicable

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: HAWAII

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
	A. General Conditions of Eligibility
	Each individual covered under the plan:
42 CFR Part 435, Subpart G	1. Is financially eligible (using the methods and standards described in Parts B and C of this Attachment) to receive services.
42 CFR Part 435, Subpart F	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.
	(ii) For SSI-related individuals, meets the non-financial criteria of the SSI progra or more restrictive SSI-related categorically needy criteria.
1902(l) of the Act	(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(l) of the Act.
1902(m) 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.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: Hawaii

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;

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: Hawaii

ELIGIBILITY CONDITIONS AND REQUIREMENTS

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

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: HAWAII

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
42 C.F.R. 435.1008	5. a. Is not an inmate of a public institution. Public institution do not include medical institutions, nursing facilities and intermediate care facilities for the mentally retarded, or publicly operated community residences that serve no more than 16 residents, or certain child care institutions.
42 C.F.R. 435.1008 1905(a) of the Act	b. Is not a patient under age 65 in an institution for mental diseases except as an inpatient under age 22 receiving active treatment in an accredited psychiatric facility or program. ☒ Not applicable with respect to individuals under age 22 in psychiatric facilities or programs. Such services are not provided under the plan.
42 C.F.R. 433.145 and 435.604 1912 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 care by a court or administrative order.) ☒ Assignment of rights is automatic because of State law.
42 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)).

Citation		Condition or Requirement
Citation:	___ 10.	Conflict of Interest Provisions
1906 of the Act		Is required to apply for enrollment in an employer-based cost-effective group health plan, if such plan is available to the individual. Enrollment is a condition of eligibility except for the individual who is unable to enroll on his/her own behalf (failure of a parent to enroll a child does not affect a child's eligibility).
U.S. Supreme Court case *New York State Department of Social Services v. Dublino, 413 U. S. 405 (1973)*	X 11.	Is required to apply for coverage under Medicare Parts A, B, and/or D if it is likely that the individual would meet the eligibility criteria for any or all of those programs. The state agrees to pay any applicable premiums and cost-sharing (except those applicable under Part D) for individuals required to apply for Medicare. Application for Medicare is a condition of eligibility unless the state does not pay the Medicare premiums, deductibles or co-insurance (except those applicable under Part D) for persons covered by the Medicaid eligibility group under which the individual is applying.

Citation	Condition or Requirement
	B. Posteligibility Treatment of Institutionalized Individuals' Incomes
	1. The following items are not considered in the posteligibility process:
1902(o) of 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.
Bondi v Sullivan (SSI)	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.
1902(r)(1) of the Act	c. German Reparations Payments (reparation payments made by the Federal Republic of Germany).
105/206 of P. L. 100-383	d. Japanese and Aleutian Restitution Payments.
1. (a) of P.L. 103-286	e. Netherlands Reparation Payments based on Nazi, but not Japanese, persecution (during World War II).
10405 of P.L. 101-239	f. Payments from the Agent Orange Settlement Fund or any other fund established pursuant to the settlement in the In re Agent Orange product liability litigation, M.D.L. No. 381 (E.D.N.Y.)
6(h)(2) of P.L. 101-426	g. Radiation Exposure Compensation.
12005 of P. L. 103-66	h. VA pensions limited to $90 per month under 38 U.S.C. 5503.

State: HAWAII

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 $ 50.00 Couples $100.00 For the following persons with greater need: Supplement 12a to Attachment 2.6-A describes the greater need; describes the basis or formula for determining the deductible amount when a specific amount is not listed above; lists the criteria to be met; and, where appropriate, identifies the organizational unit which determines that a criterion is met. b. AFDC related: Children $ 50.00 Adults $ 50.00 For the following persons with greater need: Supplement 12a to Attachment 2.6-A describes the greater need; describes the basis or formula for determining the deductible amount when a specific amount is not listed above; lists the criteria to be met; and, where appropriate, identifies the organizational unit which determines that a criterion is met. c. Individual under age 21 covered in the plan as specified in Item B. 7. of Attachment 2.2 -A. $ N/A

Citation	Condition or Requirement
	For the following persons with greater need: n/a Supplement ~~12~~ 12a to Attachment 2.6-A describes the greater need; describes the basis or formula for determining the deductible amount when a specific amount is not listed above; lists the criteria to be met; and, where appropriate, identifies the organizational unit which determines that a criterion is met.
1924 of the Act	3. In addition to the amounts under item 2. , the following monthly amounts are deducted from the remaining income of an institutionalized individual with a community spouse: a. 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. ____ 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 §1924(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.

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:

__X__ 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 copayments.

(ii) Necessary medical or remedial care recognized under State law but not covered under the State plan. (Reasonable limits on amounts are described in Supplement 3 to ATTACHMENT 2.6-A.)

Citation	Condition or Requirement
435.725 435.733 435.832	4. In addition to any amounts deductible under the items above, the following monthly amounts are deducted from the remaining monthly income of an institutionalized individual or an institutionalized couple:

a. An amount for the maintenance needs of each member of a family living in the institutionalized individual's home with no community spouse living in the home. The amount must be based on a reasonable assessment of need but must not exceed the higher of the:

- o AFDC level; or
- o Medically needy level:

(Check one)

- – AFDC levels in Supplement 1
- X Medically needy level in Supplement 1
- – Other: $_____

b. Amounts for health care expenses described below that have not been deducted under 3.c. above (i.e., for an institutionalized individual with a community spouse), are incurred by and for the institutionalized individual or institutionalized couple, and are not subject to the payment by a third party:

(I) Medicaid, Medicare, and other health insurance premiums, deductibles, or coinsurance charges, or copayments.

(ii) Necessary medical or remedial care recognized under State law but not covered under the State plan. (Reasonable limits on amount are described in Supplement 3 to ATTACHMENT 2.6-A.)

435.725 435.733 435.832	5. At the option of the State, as specified below, the following is deducted from any remaining monthly income of an institutionalized individual or an institutionalized couple:

A monthly amount for the maintenance of the home of the individual or couple for not longer than 6 months if a physician has certified that the individual, or one member of the institutionalized couple, is likely to return to the home within that period:

_X_ No.

____ Yes (the applicable amount is shown on page 5a.)

Citation	Condition or Requirement
____	Amount for maintenance of home is: $_____.
____	Amount for maintenance of home is the actual maintenance costs not to exceed $_____.
____	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.

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.

State: Hawaii

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
42 C.F.R. 435.601,435.631, 435.831	C. Financial Eligibility For individuals who are AFDC or SSI recipients, the income and resource levels and methods for determining countable income and resources of the AFDC and SSI program apply, unless the plan provides for more restrictive levels and methods than SSI for SSI recipients under section 1902(f) of the Act, or more liberal methods under section 1902(r)(2) of the Act, as specified below. For individuals who are not AFDC or SSI recipients a non-section 1902(f) State and those who are deemed to be cash assistance recipients, the financial eligibility requirements specified in this section apply. Supplement 1 to Attachment 2.6-A specifies the income levels for mandatory and optional categorically needy groups of individuals, including individuals with incomes related to 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.

State: Hawaii

ELIGIBILITY CONDITIONS AND REQUIREMENTS

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

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: HAWAII

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
1902(r)(2) of the Act	1. Methods of Determining Income
	a. AFDC-related individuals (except for poverty level related pregnant women, infants, and children).
	(1) In determining countable income for AFDC-related individuals, the following methods are used:
	X (a) The methods under the State's approved AFDC plan only; or
	___ (b) The methods under the State's approved AFDC plan and/or any s liberal methods described in Supplement 8a to ATTACHMENT 2.6
	(2) In determining relative financial responsibility, the agency considers only the income of spouses living in the same household as available to spouses and the income of parents as available to childre living with parents until the children become 21.
1902(e)(6) the Act	(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.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: HAWAII

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
42 CFR 435.721 435.831, and 1902(m)(1)(B)(m)(4) and 1902(r)(2) of the Act	b. Aged individuals. In determining countable income for aged individuals, including aged individuals with incomes up to the Federal poverty level described in section 1902(m)(1) of the Act, the following methods are used: _X_ The methods of the SSI program only. ___ The methods of the SSI program and/or any more liberal methods described in Supplement 8a to ATTACHMENT 2.6-A.

Citation	Condition or Requirement
	/X/ 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 Supplement 4 to ATTACHMENT 2.6-A; and any more liberal methods described in Supplement 8a to ATTACHMENT 2.6-A.
	/_/ 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 Supplement 4 to ATTACHMENT 2.6-A.
	/X/ For optional State supplement recipients in section 1902(f) States and SSI criteria States without section 1616 or 1634 agreements-- _X_ SSI methods. ___ SSI methods and/or any more liberal methods than SSI described in Supplement 8a to ATTACHMENT 2.6-A. _X_ Methods more restrictive and/or more liberal than SSI. More restrictive methods are described in Supplement 4 to ATTACHMENT 2.6-A and more liberal methods are described in Supplement 8a to ATTACHMENT 2.6-A.
	In determining relative financial responsibility, the agency considers only the income of spouses living in the same household as available to spouses.

Citation	Condition or Requirement
42 CFR 435.721 and 435.831 1902(m)(1)(B), (m)(4), and 1902(r)(2) of the Act	c. Blind individuals. In determining countable income for blind individuals, the following methods are used: X The methods of the SSI program. ___ SSI methods and/or any more liberal methods described in Supplement 8a to ATTACHMENT 2.6-A. X 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 Supplement 4 to ATTACHMENT 2.6-A, and any more liberal methods described in Supplement 8a to ATTACHMENT 2.6-A. ___ For institutional couples, the methods specified under section 1611(e)(3) of the Act. ___ For optional State supplement recipients under §435.230, income methods more liberal than SSI, as specified in Supplement 4 to ATTACHMENT 2.6-A. X For optional State supplement recipients in section 1902(f) States and SSI criteria States without section 1616 or 1634 agreements-- X SSI methods. ___ SSI methods and/or any more liberal methods than SSI described in Supplement 8a to ATTACHMENT 2.6-A. X Methods more restrictive and/ or more liberal than SSI. More restrictive methods are described in Supplement 4 to ATTACHMENT 2.6-A and more liberal methods are described in Supplement 8a to ATTACHMENT 2.6-A.

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, and 435.831 1902(m)(1)(B), (m)(4), and 1902(r)(2) of the Act	d. Disabled individuals. In determining countable income of disabled individuals, including individuals with incomes up to the Federal poverty level described in section 1902(m) of the Act the following methods are used: X The methods of the SSI.~~program~~ ___ SSI methods and/or any more liberal methods described in Supplement 8a to ATTACHMENT 2.6-A. ___ 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 Supplement 4 to ATTACHMENT 2.6-A. X 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 8a to ATTACHMENT 2.6-A.

Citation	Condition or Requirement
	X For optional State supplement recipients in section 1902(f) States and SSI criteria States without section 1616 or 1634 agreements--
	X SSI methods.
	___ SSI methods and/or any more liberal methods than SSI described in Supplement 8a to ATTACHMENT 2.6-A.
	X 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 Supplement 4 to ATTACHMENT 2.6-A and more liberal methods are specified in Supplement 8a to ATTACHMENT 2.6-A.
	In determining relative financial 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.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: HAWAII

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
	(2) In determining relative financial responsibility, the agency considers only the income of spouses living in the same household as available to spouses and the income of parents as available to children living with parents until the children become 21.
1902(e)(6) of the Act	(3) The agency continues to treat women eligible under the provisions of sections 1902(a)(10) of the Act as eligible, withou regard to any changes in income of the family of which she is a member, for the 60-day period after her pregnancy ends and any remaining days in the month in which t 60th day falls.
1905(p)(1), 1902(m)(4), and 1902(r)(2) of the Act	f. Qualified Medicare beneficiaries. In determining countable income for qualified Medicare beneficiaries covered under section 1902(a)(10)(E)(i) of the Act, the following methods are used: X The methods of the SSI program only. ___ SSI methods and/or any more liberal method than SSI described in Supplement 8a to ATTACHMENT 2.6-A. ___ For institutional couples, the methods specified under section 1611(e)(5) of the Act.

Citation	Condition or Requirement
	If an individual receives a title II benefit, any amounts attributable to the most recent increase in the monthly insurance benefit as a result of a 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 date of publication.
1905(s) of the Act	g. (1) Qualified disabled and working individuals. In determining countable income for qualified disabled and working individuals covered under 1902(a)(10)(E)(ii) of the Act, the methods of the SSI program are used.
1905(p) of the Act	(2) Specified low-income Medicare beneficiaries. In determining countable income for specified low-income Medicare beneficiaries covered under 1902(a)(10)(E)(iii) of the Act, the same method as in f. is used.

Citation	Condition or Requirement
1902(k) of the Act	2. Medicaid Qualifying Trusts 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 to 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. ☒ The agency does not count the funds in a trust as described above in any instance where the State determines that it would work an undue hardship. Supplement 10 of ATTACHMENT 2.6-A specifies what constitutes an undue hardship.
1902(a)(10) of the Act	3. Medically needy income levels (MNILs) are based on family size. Supplement 1 to ATTACHMENT 2.6-A specifies the MNILs for all covered medically needy groups. If the agency chooses more restrictive levels under section 1902(f) of the Act, Supplement 1 so indicates.

Citation	Condition or Requirement
42 CFR 435.732, 435.831	4. Handling of Excess Income - Spend-down for the 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 ~~either~~ one ~~or~~ ___ 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	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.

State/Territory State of Hawaii

Citation	Condition or Requirement
	Medically Needy (continued)
1902(a)(17) 435.831(g)(2) 436.831(g)(2)	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.

Citation	Condition or Requirement
	b. Categorically Needy - Section 1902 (f) States
42 CFR 435.732	The agency applies the following policy under the provisions of section 1902(f) of the Act. The following amounts are deducted from income to determine the individual's countable income: (1) Any SSI benefit received. (2) Any State supplement received that is within the scope of an agreement described in section 1616 or 1634 of the Act, or a State supplement within the scope of section 1902(a)(10)(A)(ii)(XI) of the Act. (3) Increases in OASDI that are deducted under SS435.134 and 435.135 for individuals specified in that section, in the manner elected by the State under that section. (4) Other deductions from income described in this plan at Attachment 2.6-A, Supplement 4. (5) Incurred expenses for necessary medical and remedial services recognized under State law.
1902(a)(17) of the Act, P.L. 100-203	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.

Citation	Condition or Requirement

5. Methods for Determining Resources

1902(a)(10)(A), 1902(a)(10)(C), 1902(m)(1)(B) and (C), and 1902(r) of the Act

b. Aged individuals. For aged individuals covered under section 1902(a)(10)(A)(ii)(X) of the Act, the agency used the following methods for treatment of resources:

X The methods of the SSI. ~~program~~

___ SSI methods and/or any more liberal methods described in Supplement 8b to ATTACHMENT 2.6-A.

X Methods that are more restrictive (except for individuals described in section 1902(m)(1) of the Act) and/or more liberal than those of the SSI program. Supplement 5 to ATTACHMENT 2.6-A describes the more restrictive methods and Supplement 8b to ATTACHMENT 2.6-A specifies the more liberal methods.

Citation	Condition or Requirement
	In determining relative financial responsibility, the agency considers only the resources of spouses living in the same household as available to spouses.
1902(a)(10)(A), 1902(a)(10)(C), 1902(m)(1)(B), and 1902(r) of the Act	c. Blind individuals. For blind individuals the agency uses the following methods for treatment of resources: X The methods of the SSI program. ___ SSI methods and/or any more liberal methods described in Supplement 8b to ATTACHMENT 2.6-A. X Methods that are more restrictive and/or more liberal than those of the SSI program. Supplement 5 to ATTACHMENT 2.6-A describe the more restrictive methods and Supplement 8b to ATTACHMENT 2.6-A specify the more liberal methods. In determining relative financial responsibility, the agency considers only the resources of spouses living in the same household as available to spouses and the resources of parents as available to children living with parents until the children become 21.

Citation	Condition or Requirement
1902(a)(10)(A), 1902(a)(10)(C), 1902(m)(1)(B) and (C), and 1902(r)(2) of the Act	d. Disabled individuals, including individuals covered under section 1902(a)(10)(A)(ii)(X) of the Act. The agency uses the following methods for the treatment of resources: X The methods of the SSI program. ___ SSI methods and/or any more liberal methods described in Supplement 8a to ATTACHMENT 2.6-A. X Methods that are more restrictive (except for individuals described in section 1902(m)(1) of the Act) and/or more liberal that those under the SSI program. More restrictive methods are described in Supplement 5 to ATTACHMENT 2.6-A and more liberal methods are specified in Supplement 8b to ATTACHMENT 2.6-A. In determining relative financial responsibility, the agency considers only the resources of spouses living in the same household as available to spouses and the resources of parents as available to children living with parents until the children become 21.
1902(l)(3) and 1902(r)(2) of the Act	e. Poverty level pregnant women covered under sections 1902(a)(10)(A)(i)(IV) and 1902(a)(10)(A)(ii)(IX)(A) of the Act. The agency uses the following methods in the treatment of resources. ___ The methods of the SSI program only. ___ The methods of the SSI program and/or any more liberal methods described in Supplement 5a or Supplement 8b to ATTACHMENT 2.6-A.

Citation	Condition or Requirement
	___ Methods that are more liberal than those of SSI. The more liberal methods are specified in Supplement 5a or Supplement 8b to ATTACHMENT 2.6-A.
	_X_ Not applicable. The agency does not consider resources in determining eligibility.
	In determining relative financial responsibility, the agency considers only the resources of spouses living in the same household as available to spouses and the resources of parents as available to children living with parents until the children become 21.
1902(l)(3) and 1902(r)(2) of the Act	f. Poverty level infants covered under section 1902(a)(10)(A)(i)(IV) of the Act.
	The agency uses the following methods for the treatment of resources:
	___ The methods of the State's approved AFDC plan.
	___ Methods more liberal than those in the State's approved AFDC plan (but not more restrictive), in accordance with section 1902(l)(3)(C) of the Act, as specified in Supplement 5a of ATTACHMENT 2.6-A.
1902(l)(3)(C) of the Act	
	___ Methods more liberal than those in the State's approved AFDC plan (but not more restrictive), as described in Supplement 5a or Supplement 8b to ATTACHMENT 2.6-A.
1902(r)(2) of the Act	
	_X_ Not applicable. The agency does not consider resources in determining eligibility.

Citation	Condition or Requirement
1905(p)(1)(C) and (D) and 1902(r)(2) of the Act	5. h. Qualified Medicare beneficiaries covered under section 1902(a)(10)(E)(i) 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 liberal methods as described in Supplement 8b to ATTACHMENT 2.6-A.
1905(s) of the Act	i. For qualified disabled and working individuals covered under section 1902(a)(10)(E)(ii) 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.

Citation	Condition or Requirement
1902(m)(1)(C) and (m)(2)(B) of the Act	e. For aged and disabled individuals described in section 1902(m)(1) of the Act who are covered under section 1902(a)(10)(A)(ii)(X) of the Act, the resource standard is: __X__ Same as SSI resource standards. ____ Same as the medically needy resource standards, which are higher than the SSI resource standards (if the State covers the medically needy). Supplement 2 to ATTACHMENT 2.6-A specifies the resource levels for these individuals.

State: Hawaii

Citation	Condition or Requirement
1902(a)(10)(C)(i) of the Act	7. Resource Standard –Medically Needy a. Resource standards are based on family size. b. 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 _____ Blind _____ Disabled Supplement 2 to ATTACHMENT 2.6-A specifies the resource standards for all covered medically needy groups. If the agency chooses more restrictive levels under 7.c., Supplement 2 so indicates.
1902(a)(10)(E), 1905(p)(1)(C), 1905(p)(2)(B) and 1860D-14(a)(3)(D) of the Act	8. Resource Standard – Qualified Medicare Beneficiaries, Specified Low-Income Medicare Beneficiaries and Qualifying Individuals 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.

State: Hawaii

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

9. Resource Standard - Qualified Disabled and Working Individuals

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

Citation	Condition or Requirement

10. Excess Resources

a. Categorically Needy, Qualified Medicare Beneficiaries, and Qualified Disabled and Working Individuals

Any excess resources make the individual ineligible.

b. Categorically Needy Only

☐ This State has a section 1634 agreement with SSI. Receipt of SSI is provided for individuals while disposing of excess resources.

c. Medically Needy

Any excess resources make the individual ineligible.

Citation	Condition or Requirement
42 CFR 435.914	11. Effective Date of Eligibility

a. Groups Other Than Qualified Medicare Beneficiaries

(1) For the prospective period.

Coverage is available for the full month if the following individuals are eligible at any time during the month.

X Aged, blind, disabled.
X AFDC-related.

Coverage is available only for the period during the month for which the following individuals meet the eligibility requirements.

___ Aged, blind, disabled.
___ AFDC-related.

(2) For the retroactive period.

Coverage is available for three months before the date of application if the following individuals would have been eligible had they applied:

___ Aged, blind, disabled.
___ AFDC-related.

Coverage is available beginning the first day of the third month before the date of application if the following individuals would have been eligible at any time during that month, had they applied..

X Aged, blind, disabled.
X AFDC-related.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: HAWAII

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
1920(b)(1) of the Act	___ (3) For a presumptive eligibility period for pregnant women only. Coverage is available for ambulatory prenatal care for the period that begins on the day a qualified provider determines that a woman meets any of the income eligibility levels specified in ATTACHMENT 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 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 Act	X b. For qualified Medicare beneficiaries defined in section 1905(p)(1) of the Act coverage is available beginning with the first day of the month after the month in which the individual is first determined to be a qualified Medicare beneficiary under section 1905(p)(1). The eligibility determination is valid for— X 12 months ___ 6 months ___ ___ months (no less than 6 months and no more than 12 months)

Citation	Condition or Requirement

1902(a)(10) and 1902(f) of the Act

12. **Pre-OBRA 93 Transfer of Resources - Categorically and Medically Needy, Qualified Medicare Beneficiaries, and Qualified Disabled and Working Individuals**

The agency complies with the provisions of section 1917 of the Act with respect to the transfer of resources.

Disposal of resources at less than fair market value affects eligibility for certain services as detailed in Supplement 9 to Attachment 2.6-A.

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 regard to the transfer of assets.

Disposal of assets at less than fair market value affects eligibility for certain services as detailed in Supplement 9(a) to ATTACHMENT 2.6-A, except in 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 regard to trusts.

____ The agency uses more restrictive methodologies under section 1902(f) of the Act, and applies those methodologies in dealing with trusts;

____ The agency meets the requirements in section 1917(d)(4)(B) of the Act for use of Miller trusts. 4

The agency does not count the funds in a trust in any instance where the agency determines that the transfer would work an undue hardship, as described in Supplement 10 to ATTACHMENT 2.6-A.

Citation	Condition or Requirement
1924 of the Act	13. The agency complies with the provisions of §1924 with respect to income and resource eligibility and posteligibility determinations for individuals who are expected to be institutionalized for at least 30 consecutive days and who have a spouse living in the community. When applying the formula used to determine the amount of resources in initial eligibility determinations, the State standard for community spouses is: __X__ the maximum standard permitted by law; ____ the minimum standard permitted by law; or __$__ a standard that is an amount between the minimum and the maximum.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: HAWAII

INCOME ELIGIBILITY 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(a)(3) of th Act are as follows:

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

Family Size	Income Level
1	$ *
2	$ *
3	$ *
4	$ *
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 trapsition 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.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: HAWAII

INCOME ELIGIBILITY LEVELS (Continued)

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

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

1. NON-SECTION 1902(f) STATES

a. Based on the following percent of the official Federal income poverty level:

Eff. Jan. 1, 1989: ☑ 85 percent ☐ _____ percent (no more than 100)

Eff. Jan. 1, 1990: ☑ 90 percent ☐ _____ percent (no more than 100)

Eff. Jan. 1, 1991: 100 percent

Eff. Jan. 1, 1992: 100 percent

b. Levels:

Family Size	Income Levels
1	$ *
2	$ *

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

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. SECTION 1902(f) STATES WHICH AS OF JANUARY 1, 1987 USED INCOME STANDARDS MORE RESTRICTIVE THAN SSI

a. Based on the following percent of the official Federal income poverty level:

Eff. Jan. 1, 1989: [ ] 80 percent [X] 100 percent (no more than 10

Eff. Jan. 1, 1990: [ ] 85 percent [X] 100 percent (no more than 10

Eff. Jan. 1, 1991: [ ] 95 percent [X] 100 percent (no more than 10

Eff. Jan. 1, 1992: 100 percent

b. Levels:

Family Size	Income Levels
1	$ *
2	$ *

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

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) Family Size	(2) Net income level protected for maintenance for one month	(3) Amount by which Column (2) exceeds limits specified in CFR 435.1007[1]	(4) Net income level for persons living in rural areas for ____ months	(5) Amount by which Column (4) exceeds limits specified in 42 CFR 435.1007[1]
___ Urban only				
__ Urban & rural				
1	$ 469	$	$	$
2	$ 632	$	$	$
3	$ 795	$	$	$
4	$ 958	$	$	$
For each Additional Person, Add:	$163			

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

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) Family Size	(2) Net income level protected for maintenance for one month ___urban only __ urban & rural	(3) Amount by which Column (2) exceeds limits specified in CFR 435.1007[1]	(4) Net income level for persons living in rural areas for ___ months	(5) Amount by which Column (4) exceeds limits specified in 42 CFR 435.1007[1]
5	$ 1,121	$	$	$
6	$ 1,284	$	$	$
7	$ 1,447	$	$	$
8	$ 1,610	$	$	$
9	$ 1,772	$	$	$
10	$ 1,935	$	$	$
For each Additional Person, Add:	$ 163			

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

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: HAWAII

4. Aged and Disabled Individuals

/X/ Same as SSI resource levels for an individual or a couple.

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

Family Size	Resource Level
1	
2	
3	
4	
5	

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

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: HAWAII

RESOURCE LEVELS (Continued)

B. MEDICALLY NEEDY

Applicable to all groups -

☐ 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	3,250
4	3,500
5	3,750
6	4,000
7	4,250
8	4,500
9	4,750
10	5,000
For each additional person	250

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.

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.

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.

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.

State: Hawaii

Standards for Optional State Supplementary Payments

Payment Category (Reasonable Classification)	Administered by		Income Level				Income Disregards Employed
			Gross*		Net**		
	Federal	State	1 person	Couple	1 person	Couple	
(1)	(2)		(3)		(4)		(5)
A, B, D IN DOMICILIARY CARE:	X						
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

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: HAWAII

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

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: HAWAII

RESOURCE STANDARDS FOR 1902(f) 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.

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

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

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

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

Mandatory Categorically Needy Eligibility Groups

1. Children no longer eligible for SSI because of change in definition of disability.	§1902(a)(10)(A)(i)(II)
2. Qualified pregnant women.	§1902(a)(10)(A)(i)(III), §1905(n)(1)
3. Qualified children.	§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)
7. Poverty level children under age 19.	§1902(a)(10)(A)(i)(VII), §1902(l)(1)(D)
8. Disabled individual whose earnings exceed SSI substantial gainful activity level.	§1619(a)
9. Disabled individual whose earnings are too high to receive SSI cash benefit.	§1619(b)
10. Disabled individual whose earnings are too high to receive SSI cash benefit.	§1902(a)(10)(A)(i)(II), §1905(q)
11. Pickle amendment -Would be eligible for SSI if title II COLAs were deducted from income.	Section 503 of P.L. 94-566
12. Disabled widows/widowers.	§1634(b), §1935
13. Disabled adult children.	§1634(c), §1935
14. Early widows/widowers.	§1634(d), §1935
15. Qualified Disabled and Working Individuals.	§1902(a)(10)(E)(ii), §1905(s)
16. Qualified Medicare Beneficiaries.	§1902(a)(10)(E)(i), §1905(p)(1)
17. Specified Low Income Beneficiaries.	§1902(a)(10)(E)(iii)

18. Qualified Individuals -I.	§1902(a)(10)(E)(iv)(I)
Optional Categorically Needy Eligibility Groups	
1. Meet the income and resource requirements of the appropriate cash assistance program (SSI or AFDC).	§1902(a)(10)(A)(ii)(I)
2. Would meet the income and resource requirements of AFDC if child care costs were paid from earnings rather than by a State agency.	§1902(a)(10)(A)(ii)(II)
3. Would be eligible for cash assistance (AFDC or SSI) if they were not in a medical institution. Receiving, or would be eligible to receive if they were not in a medical institution, a State supplement payment.	§1902(a)(10)(A)(ii)(IV)
4. Individuals under age 21 who are under State adoption agreements.	§1902(a)(10)(A)(ii)(VIII)
5. Aged or disabled individuals with income that does not exceed 100 percent of the Federal poverty level.	§1902(a)(10)(A)(ii)(X)
6. Receiving only an optional State supplement which is more restrictive than the criteria for an optional State supplement under title XVI.	§1902(a)(10)(A)(ii)(XI)
7. Optional targeted low income children.	§1902(a)(10)(A)(ii)(XIV)
8. Medically Needy.	§1902(a)(10)(C), §1902(a)(10)(C)(i)(III)

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(l)(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.

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.

HK remove

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

SUPPLEMENT 8a to ATTACHMENT 2.2-A
Page 6 | 6
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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).

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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:

1. 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.

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:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: HAWAII

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

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

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: HAWAII

2. 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)(i).

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:

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:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: HAWAII

No individual is ineligible by reason of item A.2 if--

(i) A satisfactory showing is made to the agency (in accordance with any regulations of the Secretary of Health and Human Services) that the individual can reasonably be expected to be discharged from the medical institution and to return to that home;

(ii) Title to the home was transferred to the individual's spouse or child who is under age 21, or (for States eligible to participate in the State program under title XVI of the Social Security Act) is blind or permanently and totally disabled or (for States not eligible to participate in the State program under title XVI of the Social Security Act) is blind or disabled as defined in section 1614 of the Act;

(iii) 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.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: HAWAII

3. 1902(f) States

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

B. Other than those procedures specified elsewhere in the supplement, the procedures for implementing denial of eligibility by reason of disposal of resources for less than fair market value are as follows:

1. If the uncompensated value of the transfer is $12,000 or less:

2. If the uncompensated value of the transfer is more than $12,000:

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.

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.

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.

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.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: HAWAII

TRANSFER OF ASSETS

1917(c) The agency provides for the denial of certain Medicaid services by reason of disposal of assets for less than fair market value.

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

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

Payments based on a level of care in a nursing 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-institutionalized individuals:

___ The agency applies these provisions to the following non-institutionalized 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:

State: HAWAII

TRANSFER OF ASSETS

3. Penalty Date--The beginning date of each penalty period imposed for 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. 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 agency;

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

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:

State: HAWAII

TRANSFER OF ASSETS

6. Penalty period for amounts of transfer less than cost of nursing 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.

b. 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.

8. Transfers made so that penalty periods would not overlap--
The agency:

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—
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:

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 certain Medicaid services upon disposing of assets for less than fair market value on or after the lookback date.

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

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

2. Non-institutionalized individuals:

   ____ The agency applies these provisions to the following non-institutionalized 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:

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);

or

- 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:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State HAWAII

TRANSFER OF ASSETS (cont.)

6. Penalty period for amounts of transfer less than cost of nursing facility care

X Where the amount of the transfer is less than the monthly cost of nursing facility care, the agency imposes a penalty for less than a full month, based on the option selected in item 4.

X The state adds together all transfers for less than fair market value made during the look-back period in more than one month and calculates a single period of ineligibility that begins on the earliest date that would otherwise apply if the transfer had been made in a single lump sum.

7. 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.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State HAWAII

TRANSFER OF ASSETS (cont.)

8. Treatment of a transfer of income

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

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

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:

(a) Notice to a recipient subject to a penalty that an undue hardship exception exists;

(b) A timely process for determining whether an undue hardship waiver will be granted; and

(c) A process, which is described in the notice, under which an adverse determination can be appealed.

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

11. Bed Hold Waivers 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).

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.

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December 1997

SUPPLEMENT ~~1~~ TO
ATTACHMENT 2.6-A
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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: HAWAII

VARIATIONS FROM THE BASIC PERSONAL NEEDS ALLOWANCE

NONE

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.

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.

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.

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.

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.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Hawaii

ASSET VERIFICATION SYSTEM

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

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

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

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

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

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State HAWAII

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

1917(f) The State agency denies reimbursement for nursing facility services and other long-term care services covered under the State Plan for an individual who does not have a spouse, child under 21, or adult disabled child residing in the individual's home, when the individual's equity interest in the home exceeds the following amount:

__ $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 waived in cases of undue hardship.

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 income-based 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.

Table 1: Adult Group Eligibility Standards and FMAP Methodology Features

Covered Populations Within New Adult Group		Applicable Population Adjustment			
Population Group	**Relevant Population Group Income Standard** For each population group, indicate the lower of: • 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".	**Resource Proxy**	**Enrollment Cap**	**Special Circumstances**	**Other Adjustments**
		Enter "Y" (Yes), "N" (No), or "NA" in the appropriate column to indicate if the population adjustment will apply to each population group. Provide additional information in corresponding attachments.			
A	**B**	**C**	**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
Childless 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

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).

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 NOT 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).

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

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	B	C	D	E	F
Conversions for FMAP Claiming Purposes						
1	**Parents/Caretaker Relatives** FPL %	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** FPL %	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** FPL %	100%	100%	yes	Part 1 of approved State MAGI conversion plan	SIPP

n/a: Not applicable.

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

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:

1) 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%

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.

Hawaii QUEST Expanded Medicaid - Demonstration Transition Plan Addendum

A. Coverage in 2014

1. 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

1. 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.

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

C. Notification Process/Notices

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

2. The state's Alternative Benefit Plan (ABP) has not yet been approved; however, Hawaii does not expect the approval of the ABP to result in any benefit changes for beneficiaries.

3. Hawaii does not intend to send any additional notices to beneficiaries moving from the demonstration to the state plan. Since this process will be seamless and not involve any change to benefits, the state feels that additional noticing would only create confusion about a process that will be seamless to the beneficiary.

D. Community Outreach

1. 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.

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

Medicaid Eligibility

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

42 CFR 435.403

State Residency

☑ 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

☒ Otherwise meet the requirements of 42 CFR 435.403.

Medicaid Eligibility

Meet the criteria specified in an interstate agreement.

◉ Yes ○ No

☒ The state has interstate agreements with the following selected states:

☒ Alabama	☒ Illinois	☒ Montana	☒ Rhode Island
☒ Alaska	☒ Indiana	☒ Nebraska	☒ South Carolina
☒ Arizona	☒ Iowa	☒ Nevada	☒ South Dakota
☒ Arkansas	☒ Kansas	☒ New Hampshire	☒ Tennessee
☒ California	☒ Kentucky	☒ New Jersey	☒ Texas
☒ Colorado	☒ Louisiana	☒ New Mexico	☒ Utah
☒ Connecticut	☒ Maine	☒ New York	☒ Vermont
☒ Delaware	☒ Maryland	☒ North Carolina	☒ Virginia
☒ District of Columbia	☒ Massachusetts	☒ North Dakota	☒ Washington
☒ Florida	☒ 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 ○ 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.

Medicaid Eligibility

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

◉ Yes ○ 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	
TRANSMITTAL NUMBER: 13-0007-MM6	**STATE:** Hawaii
PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: S89 Citizenship and Non-Citizenship Eligibility Template	**PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:** 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

Medicaid Eligibility

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 ○ 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 ○ No

The date benefits are furnished is:

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

○ The date the reasonable opportunity notice is sent.

○ Other date, as described:

Medicaid Eligibility

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 ○ No

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 ○ No

☒ Pregnant women

☒ Individuals under age 21:

○ Individuals under age 21

○ Individuals under age 20

◉ Individuals under age 19

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

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

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

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

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

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

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

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

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

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

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

   ■ Granted Deferred Action status;

   ■ Granted an administrative stay of removal under 8 CFR 241;

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

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

   ■ Has been granted employment authorization; or

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

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

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

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

9. Is a victim of severe trafficking in persons, in accordance with the Victims of Trafficking and Violence Protection Act of 2000, Pub. L. 106-386, as amended (22 U.S.C. 7105(b));

10. Exception: An individual with deferred action under the Department of Homeland Security's deferred action for the childhood arrivals process, as described in the Secretary of Homeland Security's June 15, 2012 memorandum, shall not be considered to be lawfully present with respect to any of the above categories in paragraphs (1) through (9) of this definition.

☐ Other

☑ 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

SUPERSEDING PAGES OF STATE PLAN MATERIAL	
TRANSMITTAL NUMBER: 13-0007-MM1	**STATE:** Hawaii

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

State Plan Section	Complete Pages Removed	Partial Pages Removed
Attachment 2.2-A	Page 1 Page 3 Page 3a Page 4 Page 4a Page 12 Page 13 Page 13a Page 14 Page 14a Page 21 Page 23 Page 23b	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 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 women and children - no limit on resources"
Supplement 8a to Attachment 2.6-A		Page 1, #1 Page 1, #2 delete citations for AFDC-related groups Page 2, delete citations for AFDC-related groups
Supplement 14 to Attachment 2.6-A	Page 1	
Supplement 15 to Attachment 2.6-A	Pages 1-3	

Medicaid Eligibility

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
- ( ) Standard varies by region
- ( ) Standard varies by living arrangement
- ( ) Standard varies in some other way

Medicaid Eligibility

Household size	Standard ($)
1	493
2	653
3	795
4	938
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

Additional incremental amount

◉ Yes ○ No

Increment amount $ 110

The dollar amounts increase automatically each year

○ Yes ◉ No

The standard is as follows:

◉ Statewide standard

○ Standard varies by region

○ Standard varies by living arrangement

○ Standard varies in some other way

Household size	Standard ($)
1	418
2	565
3	712
4	859
5	1,006
6	1,153
7	1,300
8	1,446
9	1,593
10	1,740
11	1,887
12	2,034
13	2,181
14	2,328
15	2,475

Additional incremental amount

◉ Yes ○ No

Increment amount $ 146

The dollar amounts increase automatically each year

○ Yes ◉ No

The standard is as follows:

○ Statewide standard

- ○ Standard varies by region
- ○ Standard varies by living arrangement
- ○ Standard varies in some other way

The dollar amounts increase automatically each year

○ Yes ○ No

The standard is as follows:

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

The dollar amounts increase automatically each year

○ Yes ○ No

The standard is as follows:

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

The dollar amounts increase automatically each year

○ Yes ○ No

The standard is as follows:

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

The dollar amounts increase automatically each year

○ Yes ○ No

The standard is as follows:

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

The dollar amounts increase automatically each year

○ Yes ○ No

The standard is as follows:

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

The dollar amounts increase automatically each year

○ 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.

Medicaid Eligibility

State Name: Hawaii

OMB Control Number: 0938-1148

Transmittal Number: 13 - 07 - 0000

Expiration date: 10/31/2014

Presumptive Eligibility by Hospitals S21

42 CFR 435.1110

One or more qualified hospitals are determining presumptive eligibility under 42 CFR 435.1110, and the state is providing Medicaid coverage for individuals determined presumptively eligible under this provision.

(•) Yes ( ) No

☑ The state attests that presumptive eligibility by hospitals is administered in accordance with the following provisions:

■ A qualified hospital is a hospital that:

■ Participates as a provider under the Medicaid state plan or a Medicaid 1115 Demonstration, notifies the Medicaid agency of its election to make presumptive eligibility determinations and agrees to make presumptive eligibility determinations consistent with state policies and procedures.

■ Has not been disqualified by the Medicaid agency for failure to make presumptive eligibility determinations in accordance with applicable state policies and procedures or for failure to meet any standards that may have been established by the Medicaid agency.

Assists individuals in completing and submitting the full application and understanding any documentation requirements.

(•) Yes ( ) No

■ The eligibility groups or populations for which hospitals determine eligibility presumptively are:

■ Pregnant Women

■ Infants and Children under Age 19

■ Parents and Other Caretaker Relatives

■ Adult Group, if covered by the state

■ Individuals above 133% FPL under Age 65, if covered by the state

■ Individuals Eligible for Family Planning Services, if covered by the state

■ Former Foster Care Children

■ Certain Individuals Needing Treatment for Breast or Cervical Cancer, if covered by the state

☐ Other Family/Adult groups:

☐ Eligibility groups for individuals age 65 and over

☐ Eligibility groups for individuals who are blind

☐ Eligibility groups for individuals with disabilities

☐ Other Medicaid state plan eligibility groups

☐ Demonstration populations covered under section 1115

Medicaid Eligibility

The state establishes standards for qualified hospitals making presumptive eligibility determinations.

(•) Yes ( ) No

Select one or both:

[☒] The state has standards that relate to the proportion of individuals determined presumptively eligible who submit a regular application, as described at 42 CFR 435.907, before the end of the presumptive eligibility period.

Description of standards:

1. An 85% accuracy rate for correctly determined applications for HPE. This will be determined analyzing the HPE applications submitted by the hospital and evaluated for accuracy by EB staff;
2. 90% of individuals are offered help from hospital PE staff to complete the full Medicaid application;
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.

[ ] The state has standards that relate to the proportion of individuals who are determined eligible for Medicaid based on the submission of an application 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 period is the earlier of:

The date the eligibility determination for regular Medicaid is made, if an application for Medicaid is filed by the last day of the month following the month in which the determination of presumptive eligibility is made; or

The last day of the month following the month in which the determination of presumptive eligibility is made, if no application for Medicaid is filed by that date.

[■] Periods of presumptive eligibility are limited as follows:

(•) No more than one period within a calendar year.

( ) No more than one period within two calendar years.

( ) No more than one period within a twelve-month period, starting with the effective date of the initial presumptive eligibility period.

( ) Other reasonable limitation:

The state requires that a written application be signed by the applicant, parent or representative, as appropriate.

(•) Yes ( ) No

( ) The state uses a single application form for Medicaid and presumptive eligibility, approved by CMS.

(•) The state uses a separate application form for presumptive eligibility, approved by CMS. A copy of the application form is included.

An attachment is submitted.

Medicaid Eligibility

■ The presumptive eligibility determination is based on the following factors:

■ The individual's categorical or non-financial eligibility for the group for which the individual's presumptive eligibility is being determined (e.g., based on age, pregnancy status, status as a parent/caretaker relative, disability, or other requirements specified in the Medicaid state plan or a Medicaid 1115 demonstration for that group)

■ Household income must not exceed the applicable income standard for the group for which the individual's presumptive eligibility is being determined, if an income standard is applicable for this group.

☒ State residency

☒ Citizenship, status as a national, or satisfactory immigration status

☑ 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 qualify for presumptive eligibility for Medicaid?

You can qualify for presumptive eligibility for Medicaid if you meet 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 past 12 months.
- If you are pregnant, you have not had presumptive eligibility for Medicaid during this pregnancy.
- You are in one of the groups that qualifies for presumptive 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.	**Ilocano** 
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** 
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 (Leave 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 different from home address) | 9. Apartment or suite number

10. City | 11. State | 12. ZIP code | 13. County

14. Phone number
( )

15. Other phone number
( )

16. Do you want to get information about this application by email? ☐ Yes ☐ No

Email address: _____

17. What is your preferred spoken language (if not English)?

18. What is your preferred 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)	Resident of 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)
				Answer for family members who are applying. If a person is not applying, you do not have to answer these questions for that person.			
(Same as above)		(Self)					

STEP 3 Other questions.

Answer these questions for yourself and your family members listed in Step 2. Your answers will make it easier to find out if you and any family member(s) qualify.

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 Security Income (SSI)? ☐ Yes ☐ No

If yes, who?_____

Is anyone who is applying for presumptive eligibility for Medicaid a parent or caretaker relative? ☐ Yes ☐ No
For example, a grandparent who is the main person taking care of a child.

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)* ☐ Weekly ☐ 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)* ☐ Weekly ☐ 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 discribmiation by visiting www.hhs.gov/ocr/office/file.
- The person who filled out Step 1 should sign this application.

Signature	Date (mm/dd/yyyy)

STEP 6 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

TN NO: 13-007-MM7 Approval Date November 18, 2015 Effective Date: January 1, 2014

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 IRS-defined 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.

Terms and Definitions

- **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.

Terms and Definitions

- **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.

Terms and Definitions

- **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:

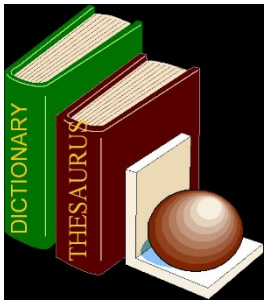
  - The child's father, mother, grandfather, grandmother, brother, sister, stepfather, stepmother, stepbrother, stepsister, uncle, aunt, first cousin, nephew, or niece;
  - The spouse of such parent or relative including same sex marriage, even after the marriage is terminated by death or divorce; or
  - 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.

Terms and Definitions

- **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.



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.

How Hospitals Can Participate in HPE

How Hospitals Can Participate in HPE

- Hospital participation in HPE is optional, 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:

1) An 85% accuracy rate for correctly determined applications for HPE. This will be determined analyzing the HPE applications submitted by the hospital and evaluated for accuracy by EB staff;
2) 90% of individuals are offered help from hospital PE staff to complete the full Medicaid application;
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.

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

2015 Standards of Assistance

HH Size	Parents or Caretaker Relatives		Adults/ Children 6-19		Children 1 < 6		Pregnant Women/ Child < 1		SCHIP Children < 19	
	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

*** 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.

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

1) 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	X	X	X	3	$1,800	Parent/Caretaker
Keira	X	X	X	3	$1,800	Parent/Caretaker
Lilly	X	X	X	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

Hospital PE Application

- 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 self-attestation 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.

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;

The HPE Determination Process (cont'd)

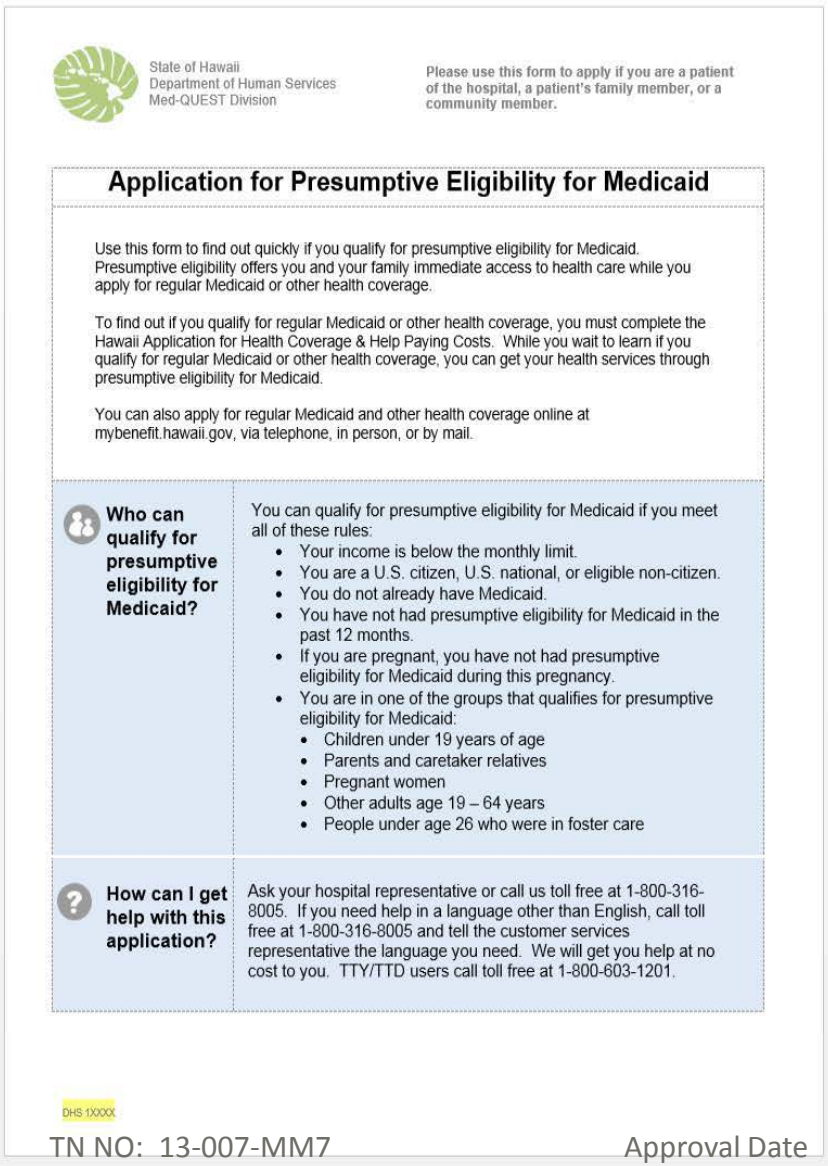
- Complete HPE eligibility determination and give applicant approval notice verifying applicant's HPE eligibility, coverage group and effective date of HPE coverage;
- Explain to applicant that the notice will serve as verification of eligibility for applicant;
- Offer assistance to applicant to apply for regular Medicaid by completing the DHS 1100 form.
- If applicant chooses not 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;
3) 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.

Hospital PE Application



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 qualify for presumptive eligibility for Medicaid?

You can qualify for presumptive eligibility for Medicaid if you meet 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 do not already have Medicaid.
- You have not had presumptive eligibility for Medicaid in the past 12 months.
- If you are pregnant, you have not had presumptive eligibility for Medicaid during this pregnancy.
- You are in one of the groups that qualifies for presumptive 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?

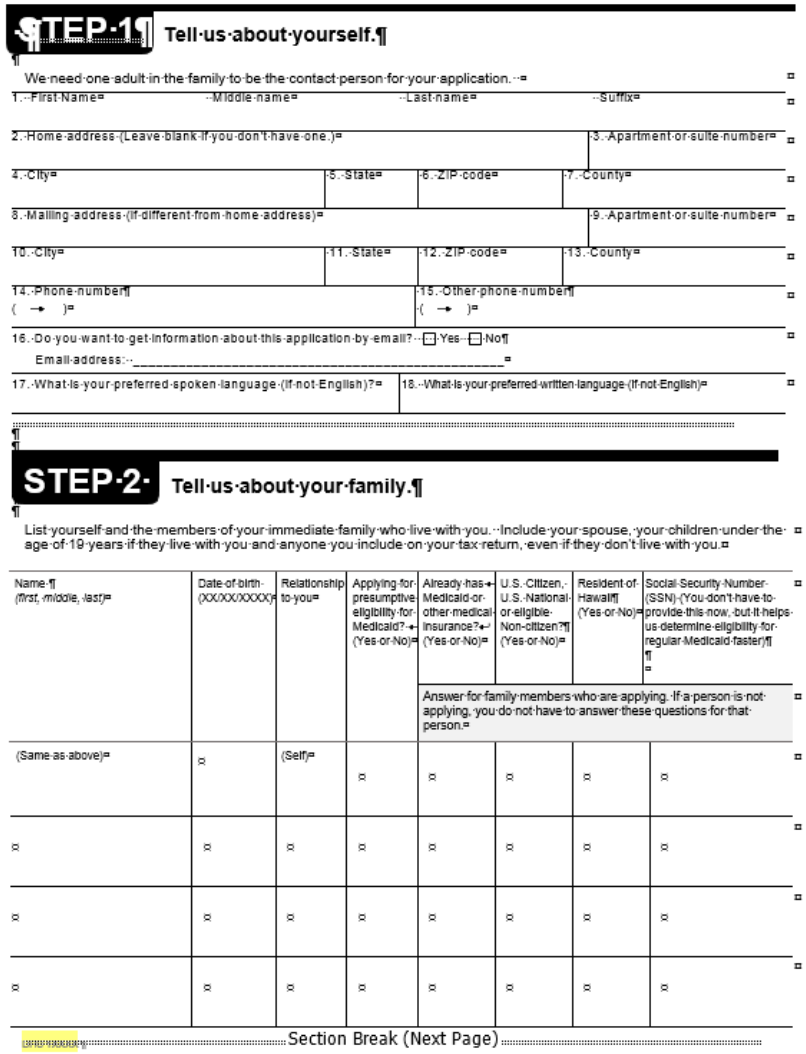
Ask your hospital representative or call us toll free at 1-800-316-8005. If you need help in a language other than English, call toll free at 1-800-316-8005 and tell the customer services representative the language you need. We will get you help at no cost to you. TTY/TTD users call toll free at 1-800-603-1201.

DHS 1XXXX

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，你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，你可以致電到 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 umawag iti 1-800-316-8005 para kadagiti amin nga serbisyo iti DHS.	Ilocano
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
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 sẽ được hỏi ngôn ngữ nào bạn nói và cú điện thoại của bạn sẽ chờ người thông dịch. Đồng thời bạn cũng 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

DHS 1XXXX

Hospital PE Application



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 (Leave 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 different from home address) | 9. Apartment or suite number

10. City | 11. State | 12. ZIP code | 13. County

14. Phone number (→) | 15. Other phone number (→)

16. Do you want to get information about this application by email? ☐ Yes ☐ No

Email address: _____

17. What is your preferred spoken language (if not English)? | 18. What is your preferred 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)	Resident of 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)
				Answer for family members who are applying. If a person is not applying, you do not have to answer these questions for that person.			
(Same as above)		(Self)					

Section Break (Next Page)

STEP 3 Other questions.

Answer these questions for yourself and your family members listed in Step 2. Your answers will make it easier to find out if you and any family member(s) qualify.

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 Security Income (SSI)?	☐ Yes ☐ 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.*

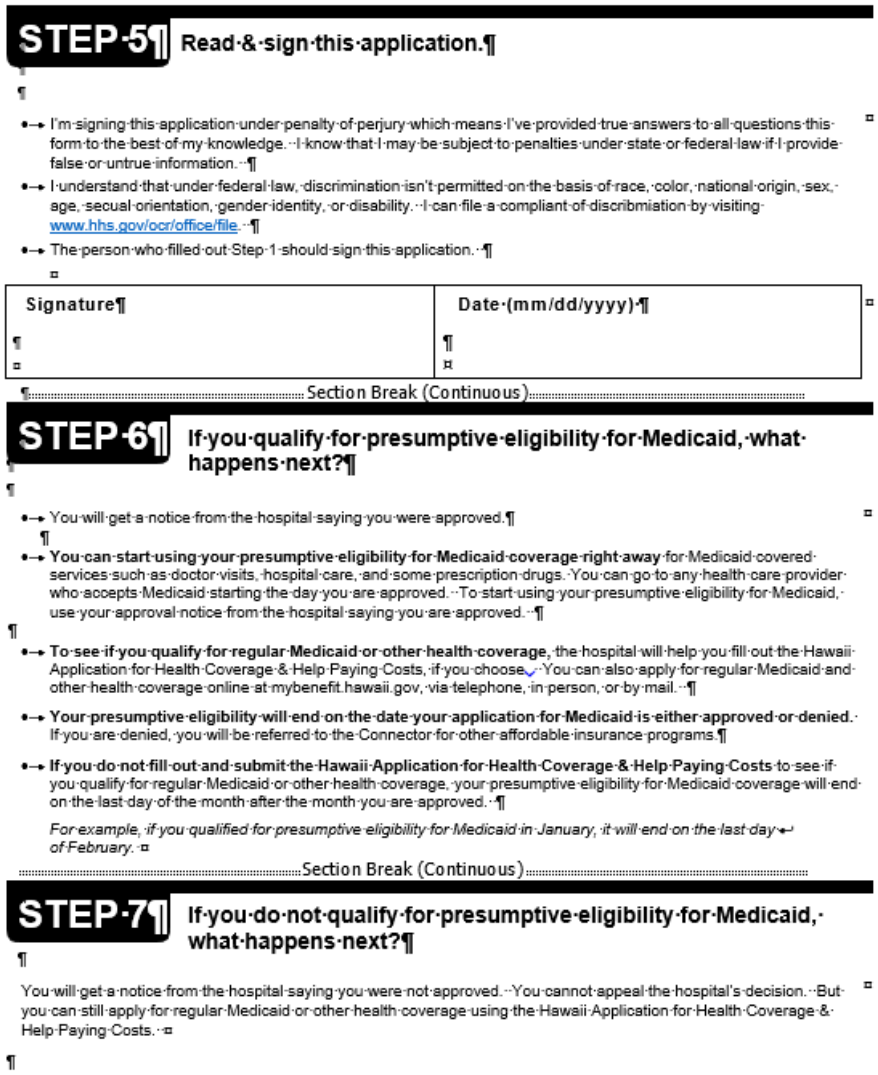
Amount $ How often? *(check one)* ☐ Weekly ☐ Biweekly ☐ Monthly ☐ Yearly

- **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)* ☐ Weekly ☐ Biweekly ☐ Monthly ☐ Yearly

DHS 1XXXX

Hospital PE Application



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 discribmiation by visiting www.hhs.gov/ocr/office/file.
- The person who filled out Step 1 should sign this application.

Signature	Date (mm/dd/yyyy)

Section Break (Continuous)

STEP 6 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.

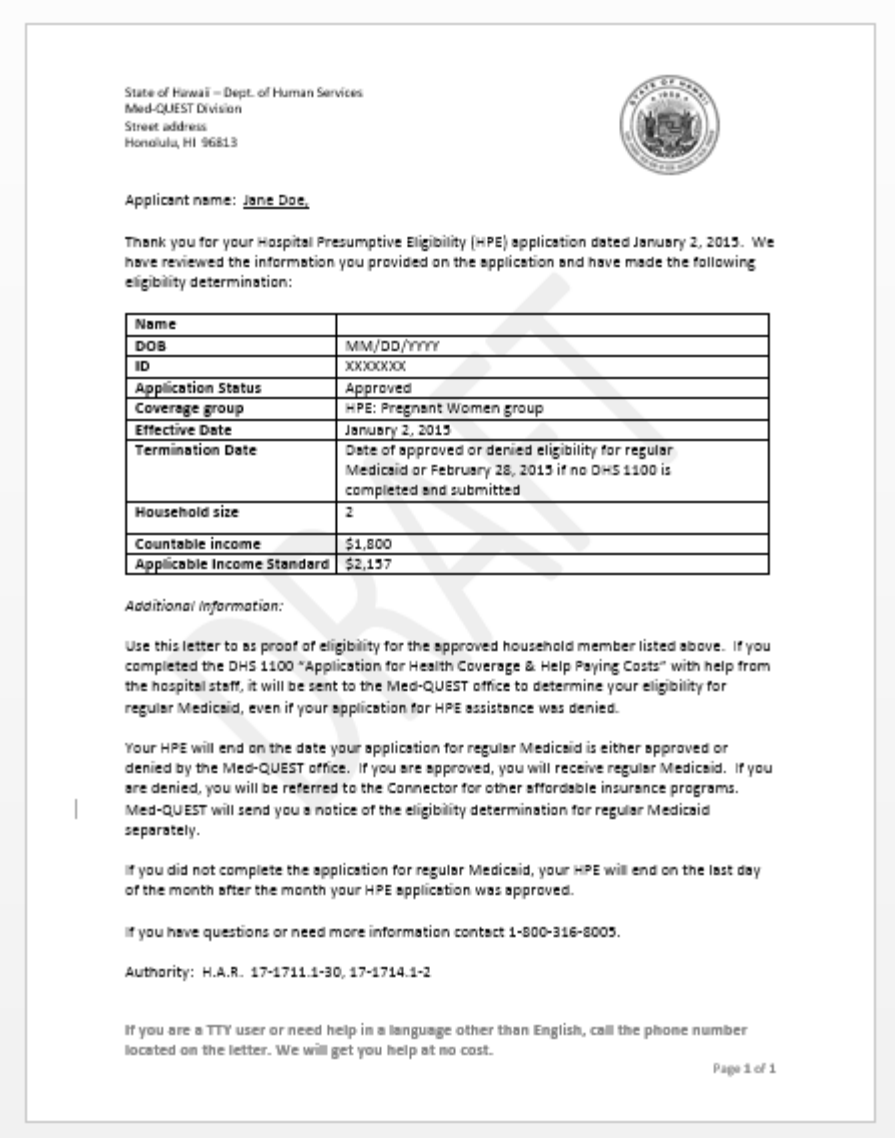
  For example, if you qualified for presumptive eligibility for Medicaid in January, it will end on the last day of February.

Section Break (Continuous)

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.

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/YYYY
ID	XXXXXX
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 DHS 1100 is completed and submitted
Household size	2
Countable income	$1,800
Applicable Income Standard	$2,137

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.

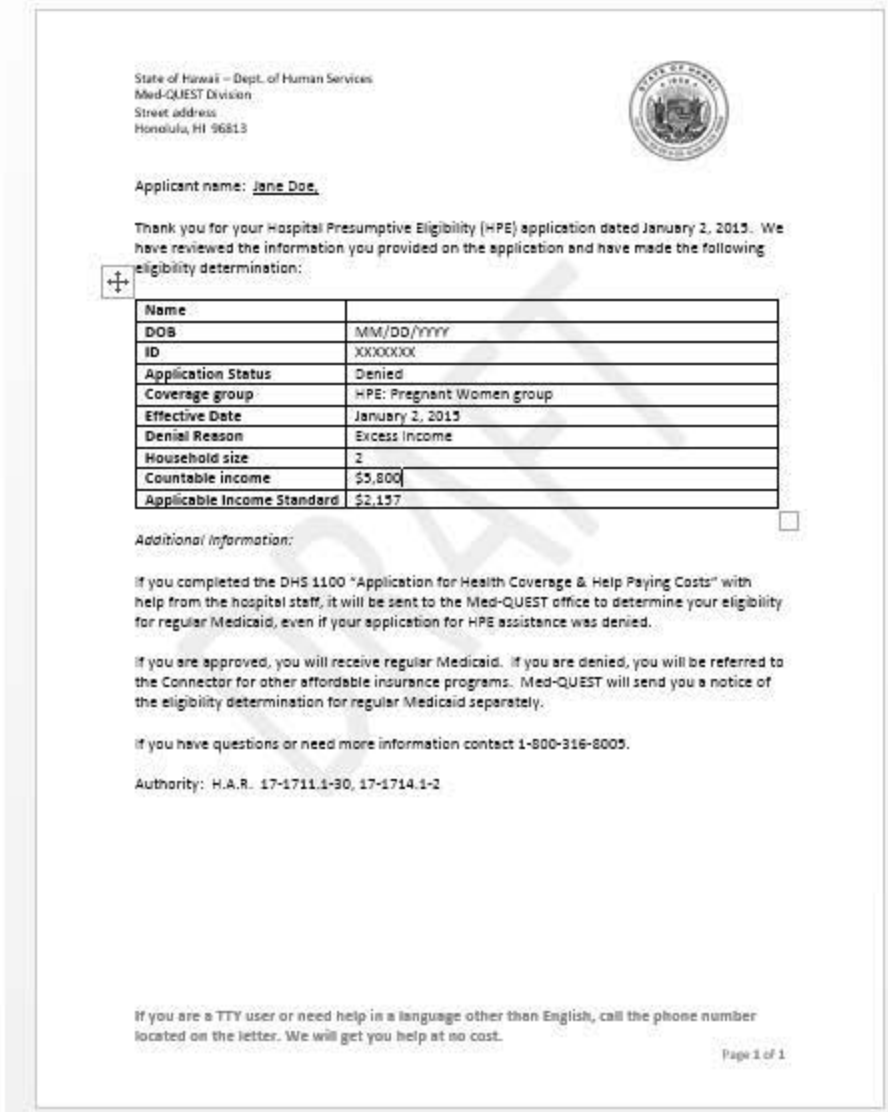
If you have questions or need more information contact 1-800-316-8005.

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 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/YYYY
ID	XXXXXXX
Application Status	Denied
Coverage group	HPE: Pregnant Women group
Effective Date	January 2, 2015
Denial Reason	Excess Income
Household size	2
Countable income	$5,800
Applicable Income Standard	$2,157

Additional information:

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.

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.

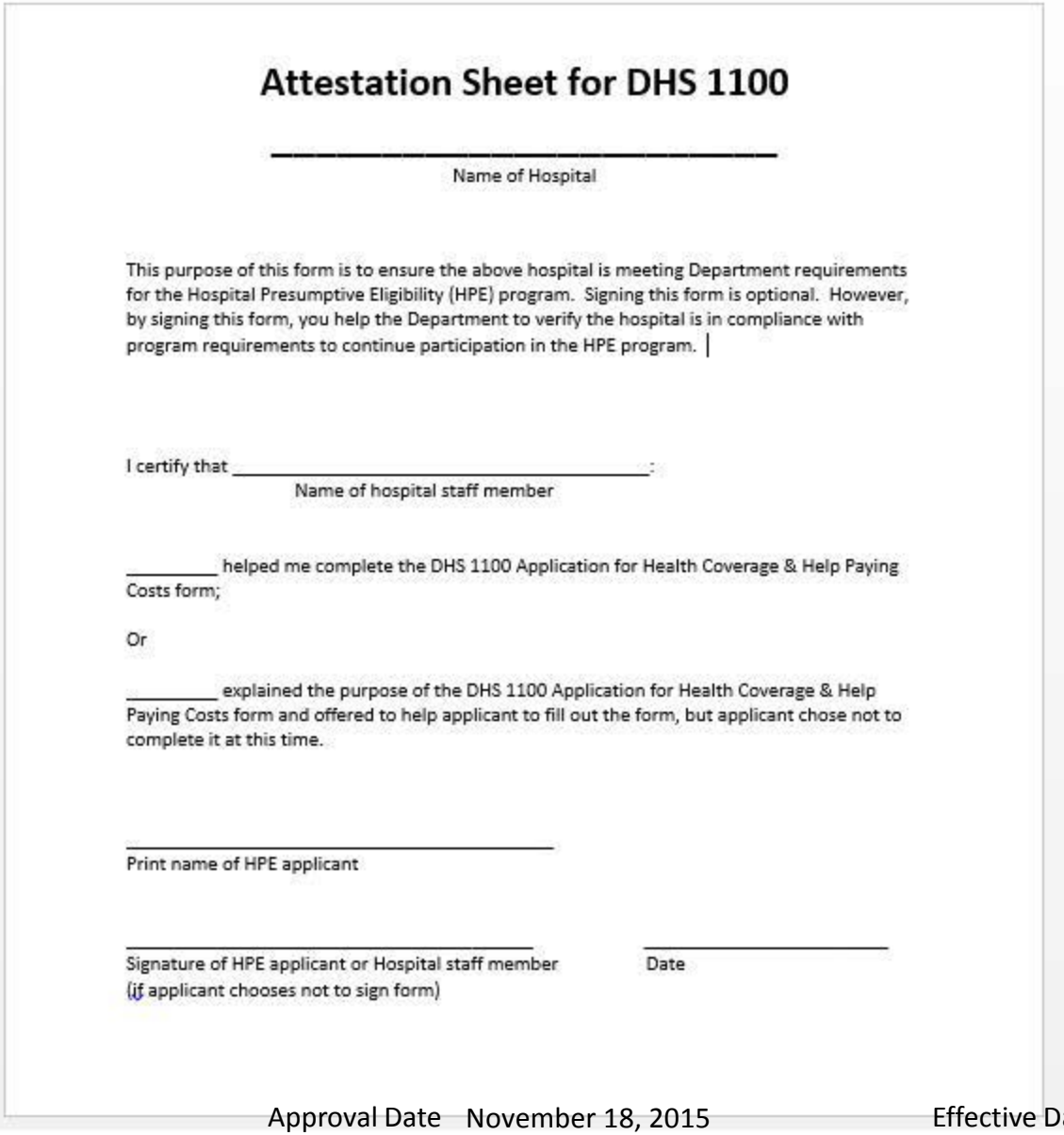
If you have questions or need more information contact 1-800-316-8005.

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

Attestation Sheet for DHS 1100



Attestation Sheet for DHS 1100

_____

Name of Hospital

This purpose of this form is to ensure the above hospital is meeting Department requirements for the Hospital Presumptive Eligibility (HPE) program. Signing this form is optional. However, by signing this form, you help the Department to verify the hospital is in compliance with program requirements to continue participation in the HPE program.

I certify that _____:

Name of hospital staff member

_____ helped me complete the DHS 1100 Application for Health Coverage & Help Paying Costs form;

Or

_____ explained the purpose of the DHS 1100 Application for Health Coverage & Help Paying Costs form and offered to help applicant to fill out the form, but applicant chose not to complete it at this time.

_____

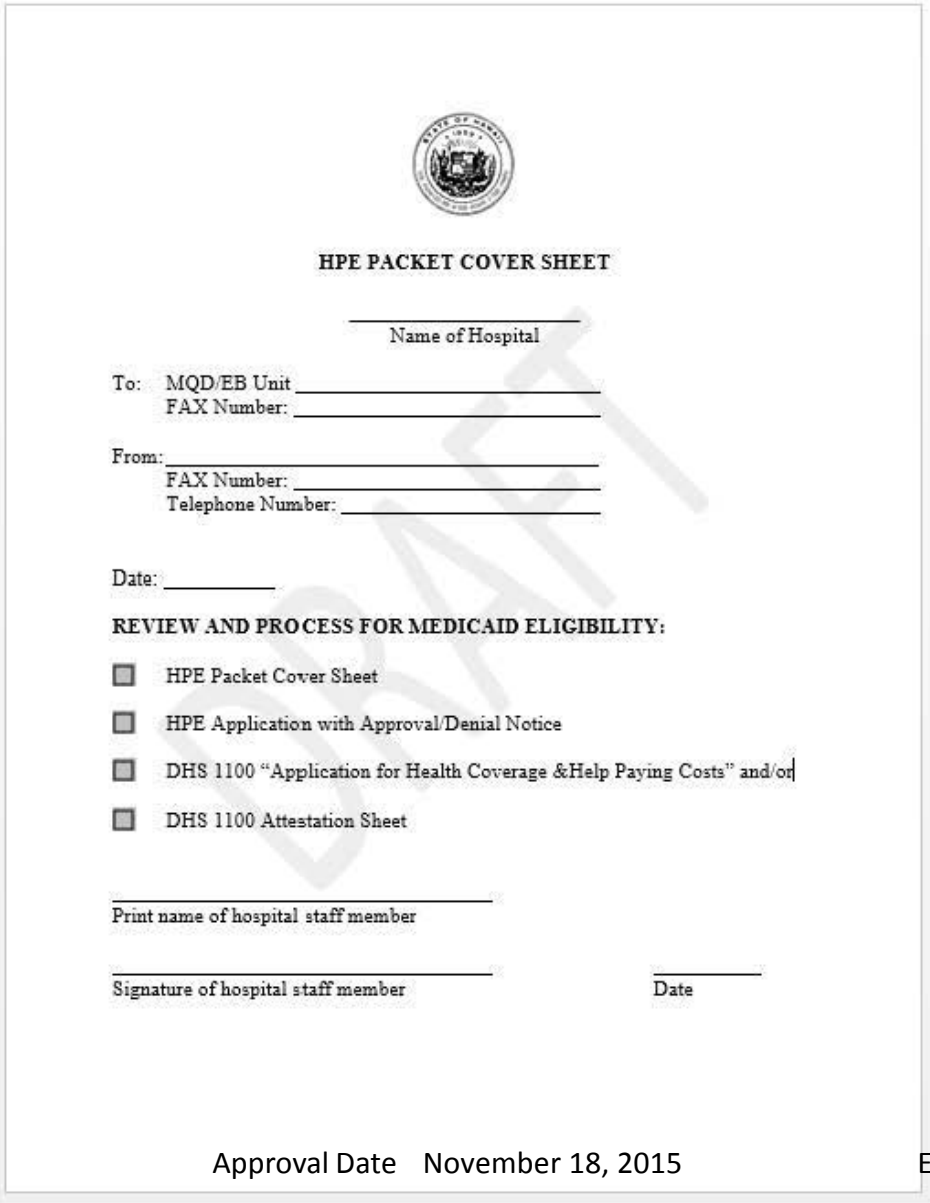
Print name of HPE applicant

_____ _____

Signature of HPE applicant or Hospital staff member (if applicant chooses not to sign form)

Date

Sample of Cover Letter



HPE PACKET COVER SHEET

_____
Name of Hospital

To: MQD/EB Unit _____
FAX Number: _____

From: _____
FAX Number: _____
Telephone Number: _____

Date: _____

REVIEW AND PROCESS FOR MEDICAID ELIGIBILITY:

- ☐ HPE Packet Cover Sheet
- ☐ HPE Application with Approval/Denial Notice
- ☐ DHS 1100 "Application for Health Coverage &Help Paying Costs" and/or
- ☐ DHS 1100 Attestation Sheet

_____
Print name of hospital staff member

_____ _____
Signature of hospital staff member Date

DHS 1100 Application for Health Coverage & Help Paying Costs

State of Hawaii
Department of Human Services
Hawaii Health Connector

Application for Health Coverage & Help Paying Costs

THINGS TO KNOW

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 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 complete Appendix C.

Apply faster online

- Apply faster online at **mybenefits.hawaii.gov**.
- 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 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 **mybenefits.hawaii.gov** 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: mybenefits.hawaii.gov**
- **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 **1-888-764-7586**.

NEED HELP WITH YOUR APPLICATION? Visit mybenefits.hawaii.gov or call us at 1-877-628-5076. Language assistance is available. 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)

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 1-888 - 764-7586 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，你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.	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 1-888-764-7586 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 1-888 - 764-7586 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 1-888-764-7586 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 1-888-764-7586 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 umawayo iti 1-888-764-7586 para kadagiti amin nga serbisyo iti DHS.	Ilocano
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１－８８８－７６４－７５８６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 위해서 1-888-764-7586 로 전화 할수 있읍니다	Korean
这是一封从人类服务部门发出的重要信件。请拔打信上的电话号码。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 1-888 - 764-7586。	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 1-888-764-7586 non aolepen ra ko kajoio 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 1-888-764-7586 mo nisi 'au'aunaga mai lenei Ofisa."	Samoan
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 1-888 - 764-7586 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 1-888-764-7586 para sa lahat ng serbisyo sa DHS.	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 trong từ các Bộ Phục Vụ Nhân Dân (DHS). Làm ơn gọi số điện thoại nằm trên lá thơ. Khi bạn gọi, bạn sẽ được hỏi ngôn ngữ nào bạn nói và cú điện thoại của bạn sẽ chờ người thông dịch. Đồng thời bạn cũng có thể gọi số 1-888-764-7586 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 1-888-764-7586 para sa tanang mga serbisyo sa DHS.	Visayan

NEED HELP WITH YOUR APPLICATION? Visit mybenefits.hawaii.gov or call us at 1-877-628-5076. Language assistance is available. 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)

DHS 1100 Application for Health Coverage & Help Paying Costs

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 (Leave 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 different from home address) | 9. Apartment or suite number

10. City | 11. State | 12. Zip code | 13. County

14. Phone number ( ) – | 15. Other phone number ( ) –

16. Do you want to get information about this application by email? ☐ Yes ☐ No

Email address: _____

17. What is your preferred spoken language (if not English)?

18. What is your preferred written language (if not English)?

19. How many family members live with you?

20. Is any family member you usually live with incarcerated (detained or jailed) or residing in the Hawaii State Hospital?
☐ Yes ☐ No
If yes, please list their name(s):

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

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

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.

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 don't 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? SELF

3. Date of birth (mm/dd/yyyy) __/__/____ 4. Gender ☐ Male ☐ Female

5. Social Security Number (SSN) ___-___-____

We need this if you want health coverage and have an SSN. Providing your SSN can be helpful if you don't want health coverage too since it can speed up the application process. We use SSNs to check income and other information to see who's eligible for help with health coverage costs. If someone wants help getting an SSN, call 1-800-772-1213 or visit **socialsecurity.gov**. TTY users should call 1-800-325-0778.

6. Do you plan to file a federal income tax return NEXT YEAR?
(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–c. ☐ **No. If no**, skip to question c.

a. Will you file jointly with a spouse? ☐ Yes ☐ No
If yes, name of spouse: _____

b. Will you claim any dependents on your tax return? ☐ Yes ☐ No
If yes, list name(s) of dependents: _____

c. Will you be claimed as a dependent on someone's tax return? ☐ Yes ☐ No
If yes, please list the name of the tax filer: _____
How are you related to the tax filer? _____

7. Are you pregnant? ☐ Yes ☐ No **If yes**, how many babies are expected during this pregnancy? _____ Expected Due Date _____

8. Do you need health coverage?
(Even if you have insurance, there 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 3. Leave **the rest** of this page blank.

9. Do you have a disability that will last more than twelve (12) months? ☐ Yes ☐ No
a. Do you currently receive long term care nursing services: ☐ **Yes**, in a nursing facility ☐ **Yes**, in my home in the community ☐ **No**
b. Have you received long term care nursing services in the last three (3) months? ☐ **Yes. If yes**, what date(s)? _____ ☐ **No**
c. Do you think you need long term care nursing services now? ☐ Yes ☐ No
d. Do you receive Supplemental Security Income (SSN)? ☐ Yes ☐ No

10. Did you receive any medical services in the past ten (10) calendar days immediately prior to the date of this application?
☐ **Yes.** If yes, what date(s)? _____ ☐ **No**

11. Are you a U.S. citizen or U.S. national? ☐ **Yes. If yes**, skip to Question 13. ☐ **No**

12. If you aren't a U.S. citizen or U.S. national, please provide the information below.
a. Immigration **document** type _____
b. Document ID number _____
c. When did you enter the U.S.? _____
d. Are you a citizen of the Federated State of Micronesia, the Republic of the Marshall Islands, and Palau. ☐ Yes ☐ No
e. Are you, or your spouse or parent, a veteran or an active-duty member of the U.S. military? ☐ Yes ☐ No

13. Are you the primary or one of the primary person(s) taking care of a child under age 19 years that lives with you? ☐ Yes ☐ No

14. Were you in foster care at age 18 or older in Hawaii? ☐ Yes ☐ No

15. Are you a full-time student? ☐ Yes ☐ No

16. If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply.)
☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other _____

17. Race (OPTIONAL – check all that apply.)

☐ White	☐ Black or African American	☐ Filipino	☐ Vietnamese	☐ Guamanian or Chamorro
☐ Asian Indian	☐ American Indian or Alaska Native	☐ Japanese	☐ Other Asian	☐ Other Pacific Islander
☐ Chinese	☐ Native Hawaiian	☐ Korean	☐ Samoan	☐ Other _____

DHS 1100 Application for Health Coverage & Help Paying Costs

STEP 2: PERSON 1 (Continue with yourself)

CURRENT Job & Income Information

☐ **Employed** If you're currently employed, tell us about your income. Start with question 18.

☐ **Self-employed** Skip to question 27.

☐ **Not employed** Skip to question 28.

CURRENT JOB 1:

18. Employer name and address

19. Employer phone number ( ) –

20. Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly

$_____

21. Average hours worked each WEEK

CURRENT JOB 2: (If you have more jobs and need more space, attach another sheet of paper.)

22. Employer name and address

23. Employer phone number ( ) –

24. Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly

$_____

25. Average hours worked each WEEK

26. In the past year, did you: ☐ Change jobs ☐ Stop working ☐ Start working fewer hours ☐ None of these

27. If self-employed, answer the following questions:

a. Type of work _____

b. How much net income (profit business expenses are paid) will you get from this self-employment this month?

$_____

28. **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	$_____	How often? _____	☐ Net farming/fishing	$_____	How often? _____
☐ Pensions	$_____	How often? _____	☐ Net rental/royalty	$_____	How often? _____
☐ Social Security	$_____	How often? _____	☐ Other income	$_____	How often? _____
☐ Retirement accounts	$_____	How often? _____	Type: _____		
☐ Alimony received	$_____	How often? _____			

29. **DEDUCTIONS:** Check all that apply, and give the amount and how often you get it.

If you pay for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower.

NOTE: You shouldn't include a cost that you already considered in your answer to net self-employment (question 27b).

☐ Alimony paid	$_____	How often? _____	☐ Other deductions	$_____	How often? _____
☐ Student loan interest	$_____	How often? _____	Type: _____		

30. **NET YEARLY INCOME:** Complete if your net income changes a lot from month to month. **If you don't expect changes to your monthly income, skip to the next person.**

Your total income this year	Your total income next year (if you think it will be different)
$	$

THANKS! This is all we need to know about you.

If there is 2 or more people to include, please make a copy of STEP 2: PERSON 2 (Pages 4 and 5) and Complete

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STEP 2: PERSON 2

Complete Step 2 for yourself, your spouse/partner and children who live with you and/or anyone on your same federal income tax return if you file one. See page 1 for more information about who to include. If you don't 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 PERSON 1?

3. Date of birth (mm/dd/yyyy) ☐☐/☐☐/☐☐☐☐ 4. Gender ☐ Male ☐ Female

5. Social Security Number (SSN) ☐☐☐-☐☐-☐☐☐☐

We need this if you want health coverage and have an SSN.

6. Does PERSON 2 live at the same address as you? ☐ Yes ☐ No

If no, list address: _____

7. Does PERSON 2 plan to file a federal income tax return NEXT YEAR?
(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–c. ☐ **No. If no**, skip to question c.

a. Will PERSON 2 file jointly with a spouse? ☐ Yes ☐ No

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: _____

c. 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 related to the tax filer? _____

8. Is PERSON 2 pregnant? ☐ Yes ☐ No **If yes**, how many babies 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.)

☐ **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.

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 a nursing facility ☐ Yes, in my home in the community ☐ No
b. Has PERSON 2 received long term care nursing services in the last three (3) months? ☐ Yes. **If yes**, what date(s)? _____ ☐ No
c. Does PERSON 2 need long term care nursing services now? ☐ Yes ☐ No
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)? _____ ☐ 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 isn't 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 citizen of the Federated State of Micronesia, the Republic of the Marshall Islands or Palau? ☐ Yes ☐ No
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 ☐ 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 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	☐ Filipino	☐ Vietnamese	☐ Guamanian or Chamorro
☐ Asian Indian	☐ American Indian or Alaska Native	☐ Japanese	☐ Other Asian	☐ Other Pacific Islander
☐ Chinese	☐ Native Hawaiian	☐ Korean	☐ Samoan	☐ Other _____

Now, tell us about any income from PERSON 2 on the back.

Effective Date: January 1, 2014

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DHS 1100 Application for Health Coverage & Help Paying Costs

STEP 2: PERSON 2

CURRENT Job & Income Information

☐ **Employed** If you're currently employed, tell us about your income. Start with question 19.

☐ **Self-employed** Skip to question 28.

☐ **Not employed** Skip to question 29.

CURRENT JOB 1:

19. Employer name and address

20. Employer phone number ( ) –

21. Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly

$_____

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 ☐ Every 2 weeks ☐ Twice a month ☐ Monthly

$_____

26. 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:**

a. Type 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 $_____ How often? _____
☐ Pensions $_____ How often? _____
☐ Social Security $_____ How often? _____
☐ Retirement accounts $_____ How often? _____
☐ Alimony received $_____ How often? _____
☐ Net farming/fishing $_____ How often? _____
☐ Net rental/royalty $_____ How often? _____
☐ Other income $_____ How often? _____
Type: _____

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.
NOTE: You shouldn't include a cost that you already considered in your answer to net self-employment (question 28b).

☐ Alimony paid $_____ How often? _____
☐ Student loan interest $_____ How often? _____
☐ Other deductions $_____ How often? _____
Type: _____

31. **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.

STEP 3 American Indian or Alaska Native (AI/AN) family member(s)

1. **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.

STEP 4 Your Family's Health Coverage

Answer these questions for anyone who need health coverage.

1. 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.

☐ Employer insurance_____
Name of health insurance:_____
Policy number:_____
Is this COBRA coverage? ☐ Yes ☐ No
Is 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**

2. 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.

PRA Disclosure Statement
According 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 control number for this information collection is 0938-1191. The time required to complete this information collection is estimated to average [Insert Time (hours or minutes)] 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 suggestion for improving this from, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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!!!SIGNATURE REQUIRED 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 years ☐ 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. 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 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
Oahu Section
P.O. Box 3490
Honolulu, HI 96811-3490

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

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

MQD/EB
West Hawaii Section
Lanihau Professional Center
75-5591 Palani Road, Suite 3004
Kailua-Kona HI 96740-3633

MQD/EB
Lanai Unit
P.O. Box 631374
Lanai City, HI 96793-0737

MQD/EB
Maui Section
Millyard Plaza
210 Imi Kala Street, Suite 101
Honolulu, HI 96820-2320

MQD/EB
Molokai Unit
P.O. Box 1619
Kaunakakai, HI 96748-1619

MQD/EB
Kauai Section
4473 Pahee Street, Suite A
Lihue, HI 96766

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

TN NO: 13-007-MM7 **Approval Date** **November 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.

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.

EMPLOYEE Information

The employee needs to fill out this section.

1. Employee name (First, Middle, Last)	2. Employee Social Security Number
	☐☐☐-☐☐-☐☐☐☐

EMPLOYER Information

Ask the employer for this section.

3. Employer name		4. Employer Identification Number (EIN)
5. Employer address (notice will be sent to this 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. Are you currently eligible for coverage offered by this employer, or will you become eligible in the next three (3) months?
☐ Yes (continue)
13a. If you're in a waiting or probationary period, when can you enroll in coverage? _____ mm/dd/yyyy
List the names of anyone else who is eligible for coverage from this job.
Name: Name: Name:
☐ No (STOP and go to Step 5 in the application)

Tell us about the health plan offered by this employer.

14. Does the employer offer a health plan that meets the minimum value standard*?
☐ **Yes** ☐ **No**

15. For the lowest-cost plan that meets the minimum value standard* offered only to the employee (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

16. What change will the employer make for the new 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.*(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 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

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DHS 1100 Application for Health Coverage & Help Paying Costs

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		4. Employer Identification Number (EIN)
5. Employer address (notice will be sent to this 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/yyyy (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)
☐ **No**

(Go to question 14)

14. Does the employer offer a health plan that meets the minimum value standard*?
☐ **Yes** (Go to question 15) ☐ **No** (**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 16. 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 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

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APPENDIX B

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 Last	First Middle 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, or 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, or 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, or urban Indian health programs, or through a referral from one of these programs? ☐ **Yes** ☐ **No**
4. 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: • 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 reservations). • Money from selling things that have cultural significance.	$_____ How often?_____	$_____ How often?_____

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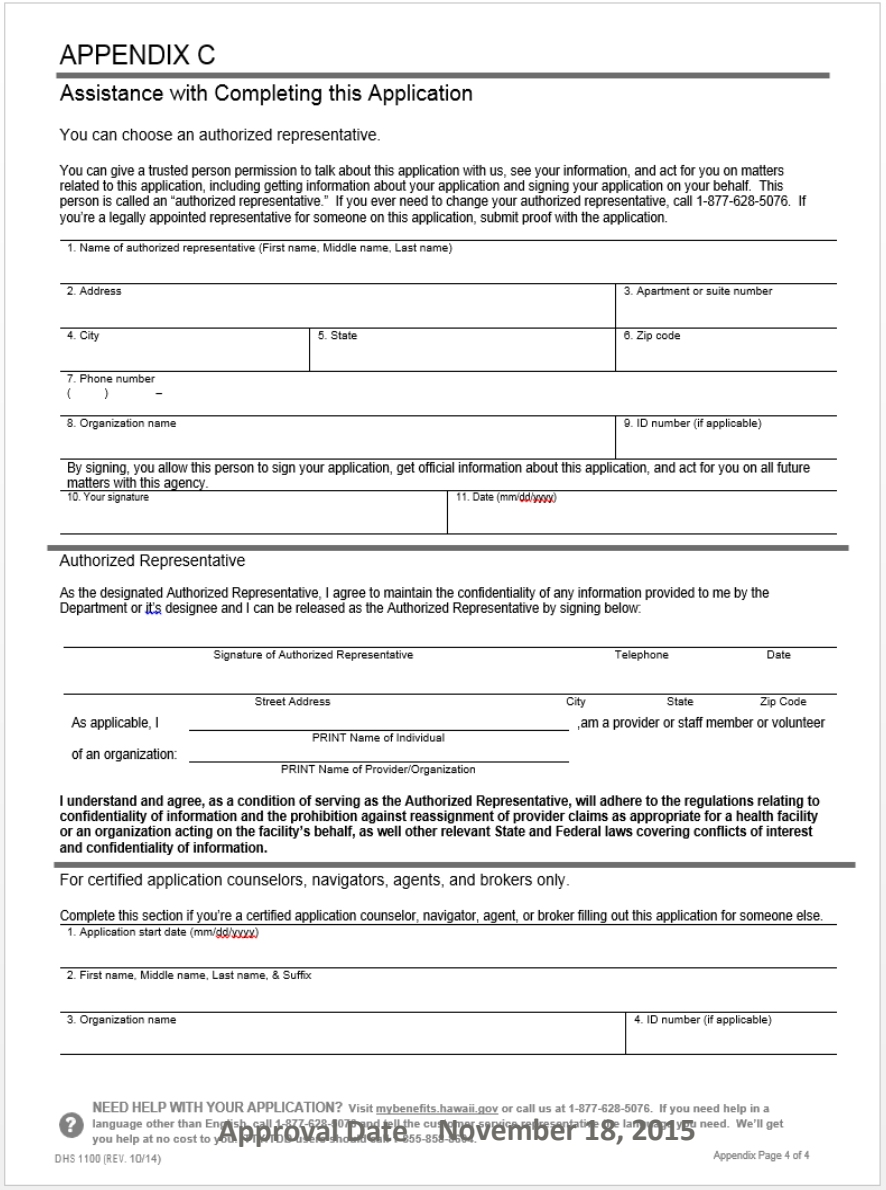
DHS 1100 Application for Health Coverage & Help Paying Costs



APPENDIX C

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're 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. Address | 3. Apartment or suite number

4. City | 5. State | 6. Zip code

7. Phone number
( ) –

8. Organization name | 9. ID number (if applicable)

By signing, you allow this person to sign your application, get official information about this application, and act for you on all future matters with this agency.

10. Your signature | 11. Date (mm/dd/yyyy)

Authorized Representative

As the designated Authorized Representative, I agree to maintain the confidentiality of any information provided to me by the Department or its designee and I can be released as the Authorized Representative by signing below:

Signature of Authorized Representative | Telephone | Date

Street Address | City | State | Zip Code

As applicable, I _____ ,am a provider or staff member or volunteer
PRINT Name of Individual

of an organization: _____
PRINT Name of Provider/Organization

I understand and agree, as a condition of serving as the Authorized Representative, will adhere to the regulations relating to confidentiality of information and the prohibition against reassignment of provider claims as appropriate for a health facility or an organization acting on the facility's behalf, as well other relevant State and Federal laws covering conflicts of interest and confidentiality of information.

For certified application counselors, navigators, agents, and brokers only.

Complete this section if you're a certified application counselor, navigator, agent, or broker filling out this application for someone else.

1. Application start date (mm/dd/yyyy)

2. First name, Middle name, Last name, & Suffix

3. Organization name | 4. ID number (if applicable)

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DHS 1100 (REV. 10/14) Appendix Page 4 of 4

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

Medicaid Eligibility

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

42 CFR 435.110
1902(a)(10)(A)(i)(I)
1931(b) and (d)

■ **Parents and Other Caretaker Relatives** - Parents and other caretaker relatives of dependent children 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 qualifying under this eligibility group must meet the following criteria:

■ Are parents or other caretaker relatives (defined at 42 CFR 435.4), including pregnant women, of dependent children (defined at 42 CFR 435.4) under age 18. Spouses of parents and other caretaker relatives are also included.

The state elects the following options:

☒ This eligibility group includes individuals who are parents or other caretakers of children who are 18 years old, provided the children are full-time students in a secondary school or the equivalent level of vocational or technical training.

☒ Options relating to the definition of caretaker relative (select any that apply):

☐ The definition of caretaker relative includes the domestic partner of the parent or other caretaker relative, even after the partnership is terminated.

Definition of domestic partner:

☐ The definition of caretaker relative includes other relatives of the child based on blood (including those of half-blood), adoption or marriage.

Description of other relatives:

☒ The definition of caretaker relative includes any adult with whom the child is living and who assumes primary responsibility for the dependent child's care.

☒ Options relating to the definition of dependent child (select the one that applies):

◉ The state elects to eliminate the requirement that a dependent child must be deprived of parental support or care by reason of the death, physical or mental incapacity, or absence from the home or unemployment of at least one parent.

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

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■ Have household income at or below the standard established by the state.

■ MAGI-based income methodologies are used in calculating household income. Please refer as necessary to S10 MAGI-Based Income Methodologies, completed by the state.

■ Income standard used for this group

■ Minimum income standard

The minimum income standard used for this group is the state's AFDC payment standard in effect as of May 1, 1988, converted to MAGI-equivalent amounts by household size. The standard is described in S14 AFDC Income Standards.

☑ The state certifies that it has submitted and received approval for its converted May 1, 1988 AFDC payment standard.

[redacted]

■ Maximum income standard

☑ The state certifies that it has submitted and received approval for its converted income standard(s) for parents and other caretaker relatives to MAGI-equivalent standards and the determination of the maximum income standard to be used for parents and other caretaker relatives under this eligibility group.

[redacted]

The state's maximum income standard for this eligibility group is:

○ 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 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:

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- (◉) 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.
- ( ) The state's TANF payment standard, converted to a MAGI-equivalent standard. The standard is described in S14 AFDC Income Standards.
- ( ) Other dollar amount

(■) Income standard chosen:

Indicate the state's income standard used for this eligibility group:

- ( ) 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.
- ( ) Another income standard in-between the minimum and maximum standards allowed

(■) There is no resource test for this eligibility group.

(■) Presumptive Eligibility

The state covers individuals under this group when determined presumptively eligible by a qualified entity. The state assures it also covers individuals under the Pregnant Women (42 CFR 435.116) and/or Infants and Children under Age 19 (42 CFR 435.118) eligibility groups when determined presumptively eligible.

( ) Yes (◉) No

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.

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42 CFR 435.116
1902(a)(10)(A)(i)(III) and (IV)
1902(a)(10)(A)(ii)(I), (IV) and (IX)
1931(b) and (d)
1920

■ **Pregnant Women** - Women 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 qualifying under this eligibility group must be pregnant or post-partum, as defined in 42 CFR 435.4.

Pregnant women in the last trimester of their pregnancy without dependent children are eligible for full benefits under this group in accordance with section 1931 of the Act, if they meet the income standard for state plan Parents and Other Caretaker Relatives at 42 CFR 435.110.

○ Yes ◉ No

■ 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 (Once entered and approved by CMS, the minimum income standard cannot be changed.)

The state had an income standard higher than 133% FPL established as of December 19, 1989 for determining eligibility for pregnant women, or as of July 1, 1989, had authorizing legislation to do so.

◉ Yes ○ 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 pregnant women to MAGI-equivalent standards and the determination of the maximum income standard to be used for pregnant women under this eligibility group.

[redacted]

The state's maximum income standard for this eligibility group is:

○ 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 March 23, 2010, converted to a MAGI-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.

○ 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.

○ 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.

○ 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:

○ The minimum income standard

◉ The maximum income standard

○ Another income standard in-between the minimum and maximum standards allowed.

■ There is no resource test for this eligibility group.

■ Benefits for individuals in this eligibility group consist of the following:

◉ All pregnant women eligible under this group receive full Medicaid coverage under this state plan.

○ Pregnant women whose income exceeds the income limit specified below for full coverage of pregnant women receive only pregnancy-related services.

■ Presumptive Eligibility

The state covers ambulatory prenatal care for individuals under this group when determined presumptively eligible by a qualified entity.

○ Yes ◉ No

PRA Disclosure Statement

Medicaid Eligibility

OMB Control Number 0938-1148
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42 CFR 435.118
1902(a)(10)(A)(i)(III), (IV), (VI) and (VII)
1902(a)(10)(A)(ii)(IV) and (IX)
1931(b) and (d)

■ **Infants and Children under Age 19** - Infants and children under age 19 with household income at or below standards established by the state based on age group.

☑ The state attests that it operates this eligibility group in accordance with the following provisions:

■ Children qualifying under this eligibility group must meet the following criteria:

■ Are under age 19

■ Have household income at or below the standard established by the state.

■ MAGI-based income methodologies are used in calculating household income. Please refer as necessary to S10 MAGI-Based Income Methodologies, completed by the state.

■ Income standard used for infants under age one

■ Minimum income standard

The state had an income standard higher than 133% FPL established as of December 19, 1989 for determining eligibility for infants under age one, or as of July 1, 1989, had authorizing legislation to do so.

◉ Yes ○ 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 used for infants under age one.

[redacted]

The state's maximum income standard for this age group is:

○ The state's highest effective income level for coverage of infants under age one under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(IV) (mandatory poverty level-related infants), 1902(a)(10)(A)(ii)(IX) (optional poverty level-related infants) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

Medicaid Eligibility

◉ The state's highest effective income level for coverage of infants under age one under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(IV) (mandatory poverty level-related infants), 1902(a)(10)(A)(ii)(IX) (optional poverty level-related infants) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

○ 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.

○ 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.

○ 185% FPL

Enter the amount of the maximum income standard: 191 % FPL

■ Income standard chosen

The state's income standard used for infants under age one is:

◉ The maximum income standard

○ If not chosen as the maximum income standard, the state's highest effective income level for coverage of infants under age one under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(IV) (mandatory poverty level-related infants), 1902(a)(10)(A)(ii)(IX) (optional poverty level-related infants) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

○ If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's highest effective income level for coverage of infants under age one under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(IV) (mandatory poverty level-related infants), 1902(a)(10)(A)(ii)(IX) (optional poverty level-related infants) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

○ If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's effective income level for any population of infants under age one under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

○ If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's effective income level for any population of infants under age one under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

○ Another income standard in-between the minimum and maximum standards allowed, provided it is higher than the effective income standard for this age group in the state plan as of March 23, 2010.

■ Income standard for children age one through age five, inclusive

■ Minimum income standard

Medicaid Eligibility

The minimum income standard used for this age group is 133% FPL.

■ Maximum income standard

☑ The state certifies that it has submitted and received approval for its converted income standard(s) for children age one through five to MAGI-equivalent standards and the determination of the maximum income standard to be used for children age one through five.

[redacted]

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)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

◉ The state's highest effective income level for coverage of children age 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.

○ 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.

○ The state's effective income level for any population of children age one through five under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

Enter the amount of the maximum income standard: 139 % FPL

■ Income standard chosen

The state's income standard used for children age one through five is:

◉ The maximum income standard

○ If not chosen as the maximum income standard, the state's highest effective income level for coverage of children age one through five under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(VI) (mandatory poverty level-related children age one through five), and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

○ If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, 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)(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 one through five under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

○ If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's effective income level for any population of children age one through five under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

○ Another income standard in-between the minimum and maximum standards allowed, provided it is higher than the effective income standard for this age group in the state plan as of March 23, 2010.

■ Income standard for children age six through age eighteen, inclusive

■ Minimum income standard

The minimum income standard used for this age group is 133% FPL.

■ Maximum income standard

☑ The state certifies that it has submitted and received approval for its converted income standard(s) for children age six through eighteen to MAGI-equivalent standards and the determination of the maximum income standard to be used for children age six through age eighteen.

[redacted]

The state's maximum income standard for children age six through eighteen is:

○ The state's highest effective income level for coverage of children age six through eighteen under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(VII) (mandatory poverty level-related children age six through eighteen) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

○ The state's highest effective income level for coverage of children age six through eighteen under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(VII) (mandatory poverty level-related children age six through eighteen) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

○ 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.

○ The state's effective income level for any population of children age six through eighteen under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

◉ 133% FPL

■ Income standard chosen

The state's income standard used for children age six through eighteen is:

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◉ The maximum income standard

If not chosen as the maximum income standard, the state's highest effective income level for coverage of children age six through eighteen under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), ○ 1902(a)(10)(A)(i)(VII) (mandatory poverty level-related children age six through eighteen) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's highest effective income level for coverage of children age six through eighteen under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), ○ 1902(a)(10)(A)(i)(VII) (mandatory poverty level-related children age six through eighteen) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's effective income level for any population of children ○ age six through eighteen under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's effective income level for any population of children ○ age six through eighteen under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

○ Another income standard in-between the minimum and maximum standards allowed, provided it is higher than the effective income standard for this age group in the state plan as of March 23, 2010.

■ There is no resource test for this eligibility group.

■ Presumptive Eligibility

The state covers children when determined presumptively eligible by a qualified entity.

○ 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.

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

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

◉ Yes ○ 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.

○ Under age 19, or

◉ A higher age of children, if any, covered under 42 CFR 435.222 on March 23, 2010:

○ Under age 20

◉ Under age 21

■ Presumptive Eligibility

The state covers individuals under this group when determined presumptively eligible by a qualified entity. The state assures it also covers individuals under the Pregnant Women (42 CFR 435.116) and/or Infants and Children under Age 19 (42 CFR 435.118) eligibility groups when determined presumptively eligible.

○ Yes ◉ No

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Medicaid Eligibility

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

42 CFR 435.150
1902(a)(10)(A)(i)(IX)

■ **Former Foster Care Children** - Individuals under the age of 26, not otherwise mandatorily eligible, who were on Medicaid and in foster 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.

○ Yes ◉ No

The state covers individuals under this group when determined presumptively eligible by a qualified entity. The state assures it also covers individuals under the Pregnant Women (42 CFR 435.116) and/or Infants and Children under Age 19 (42 CFR 435.118) eligibility groups when determined presumptively eligible.

○ Yes ◉ No

Medicaid Eligibility

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.

○ Yes ◉ No

PRA Disclosure Statement

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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 ○ 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:

■ 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 ○ No

■ Minimum income standard

The income standard used for this eligibility group must exceed the income standard established for the mandatory Parents and Other Caretaker Relatives eligibility group (42 CFR 435.110). Please refer as necessary to S25 Parents and Other Caretaker Relatives for the income standard chosen for that group.

■ Maximum income standard

☑ The state certifies that it has submitted and received approval for its converted income standard(s) for optionally eligible parents and other caretaker relatives to MAGI-equivalent standards and the determination of the maximum income standard to be used for parents and other caretaker relatives under this eligibility group.

[redacted]

The state's maximum income standard for this eligibility group is:

○ 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 state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL or amounts by household size.

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

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 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 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:

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 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 been completed in S14 AFDC Income Standards, complete and submit it with this eligibility group. If it has already been completed, refer to it as necessary.

If not chosen as the maximum income standard, the state's AFDC payment standard in effect as of July 16, 1996, converted to a MAGI-equivalent standard. If this standard has not been completed in S14 AFDC Income Standards, complete and submit it with this eligibility group. If it has already been completed, refer to it as necessary.

If not chosen as the maximum income standard, the state's TANF payment standard, converted to a MAGI-equivalent 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 %

Other dollar amount

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.

Medicaid Eligibility

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

Eligibility Groups - Options for Coverage
Reasonable Classification of Individuals under Age 21

S52

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 ( ) 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 ( ) 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.

( ) 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 ( ) 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.

( ) Yes (●) No

Medicaid Eligibility

The state covers reasonable classifications of children that were covered under the Medicaid state plan as of December 31, 2013 or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013 with an income standard higher than the current mandatory income standard for the age group.

◉ Yes ○ No

The previously covered reasonable classifications to be included are:

Previously Covered Reasonable Classifications Included

Reasonable Classifications of Children **S11**

☐ 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	X

Enter the income standard used for these classifications (which may be no higher than the highest standard used in the Medicaid state plan as of December 31, 2013 or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013).

Click here once S11 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

No income test was used (all income was disregarded) for this classification either in the Medicaid state plan as of December 31, 2013, or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013.

(●) Yes ( ) No

The state's maximum standard for this classification of children is no income test (all income is disregarded).

[■] Income standard chosen

Individuals qualify under this classification under the following income standard:

(●) This classification does not use an income test (all income is disregarded).

( ) Another income standard higher than the minimum income standard.

New reasonable classifications covered

If the state has not elected to cover the Adult Group (42 CFR 435.119), it may elect to cover additional new age groups or reasonable classifications that have not been covered previously. If the state covers the Adult Group, this additional option is not available, as the standard for the new age groups or classifications is lower than that used for mandatory coverage.

The state does not 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.

( ) Yes (●) No

[■] There is no resource test for this eligibility group.

PRA Disclosure Statement

Medicaid Eligibility

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

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

Children with Non IV-E Adoption 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 ○ 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
○ Under age 20
○ Under age 19
○ 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 ○ No

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

◉ Yes ○ 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.

○ Yes ◉ No

■ There is no resource test for this eligibility group.

Medicaid Eligibility

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 ○ 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 ○ No

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

◉ Yes ○ 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:

◉ Under age 19

○ Under age 18

○ 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

Medicaid Eligibility

☑ 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.

[redacted]

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

○ The state's effective income level for this classification of children under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

◉ The state's effective income level for this classification of children under the Medicaid State Plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

○ The state's effective income level for this classification of children under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

○ 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.

○ 200% FPL.

○ 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.

○ 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 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 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 income level for this eligibility group under a Medicaid 1115 demonstration 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, 200% FPL.

Medicaid Eligibility

○ If higher than the effective income level used under the state plan as of March 23, 2010, 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.

○ 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

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Medicaid Eligibility

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

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Medicaid Eligibility

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.

○ Yes ◉ No

PRA Disclosure Statement

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Medicaid Eligibility

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.

○ Yes ◉ No

PRA Disclosure Statement

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ATTACHMENT 2

RI: converted thresholds
date: 09-APR-2013

population/type	applicant type	citiation	unit size	original standard	converted standard
Family - 1988	applicant	AFDC 5/1/1988	1	$327	$493
			2	$430	$653
			3	$515	$795
			4	$601	$938
			5	$689	$1,083
			6	$780	$1,232
			7	$882	$1,391
			8	$942	$1,508
			9	$1,000	$1,623
			10	$1,059	$1,739
			11	$1,119	$1,857
			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
			3	$515	$633
			4	$601	$744
			5	$689	$856
			6	$780	$971
			7	$882	$1,097
			8	$942	$1,181
			9	$1,000	$1,263
			10	$1,059	$1,347
			11	$1,119	$1,431
			12	$1,179	$1,515
			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
			2	$430	$512
			3	$515	$618
			4	$601	$725
			5	$689	$834
			6	$780	$947
			7	$882	$1,070
			8	$942	$1,151
			9	$1,000	$1,230
			10	$1,059	$1,310
			11	$1,119	$1,391
			12	$1,179	$1,472
			13	$1,239	$1,553
			14	$1,299	$1,634
			15	$1,359	$1,715
			addon	$60	$78
Family - 1996	applicant	AFDC 7/16/1996	1	$418	$630
			2	$565	$851
			3	$712	$1,071
			4	$859	$1,291
			5	$1,006	$1,511
			6	$1,153	$1,732
			7	$1,300	$1,952
			8	$1,446	$2,171
			9	$1,593	$2,392
			10	$1,740	$2,612
			11	$1,887	$2,832
			12	$2,034	$3,052
			13	$2,181	$3,273
			14	$2,328	$3,493
			15	$2,475	$3,713
			addon	$146	$210
	ben 4 months	AFDC 7/16/1996	1	$418	$479
			2	$565	$647
			3	$712	$815

			4	$859	$983
			5	$1,006	$1,151
			6	$1,153	$1,319
			7	$1,300	$1,487
			8	$1,446	$1,654
			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
			15	$2,475	$2,831
			addon	$146	$164
	ben 8 months	AFDC 7/16/1996	1	$418	$469
			2	$565	$634
			3	$712	$799
			4	$859	$964
			5	$1,006	$1,129
			6	$1,153	$1,293
			7	$1,300	$1,458
			8	$1,446	$1,622
			9	$1,593	$1,787
			10	$1,740	$1,951
			11	$1,887	$2,116
			12	$2,034	$2,281
			13	$2,181	$2,446
			14	$2,328	$2,610
			15	$2,475	$2,775
			addon	$146	$161
Pregnant and children <1		1902(a)(10)(A)(i)(IV) mandatory poverty-level related pregnant women covered for pregnancy-related services and mandatory poverty-level related infan		185% FPL	191% FPL
Child 1-5		1902(a)(10)(A)(i)(VI) mandatory poverty-level related children aged 1-5		133% FPL	139% FPL
Child 6-18		1902(a)(10)(A)(i)(VII) mandatory poverty-level related children aged 6-18		100% FPL	105% FPL
Adult 19-64		1115		200% FPL	208% FPL
Children <19 (>150/133/100% F		M-CHIP children <19 1902(a)(10)(A)(ii)(XIV)		300% FPL	308% FPL

SUPERSEDING PAGES OF STATE PLAN MATERIAL	
TRANSMITTAL NUMBER: 13-0007-MM3	**STATE:** Hawaii
PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: S10 - MAGI Income Methodology	**PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:** 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.

Medicaid Eligibility

State Name: Hawaii

OMB Control Number: 0938-1148

Transmittal Number: 15 - - 0002

Expiration date: 10/31/2014

MAGI-Based Income Methodologies — S10

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.
- ○ The pregnant woman is counted as herself, plus one.
- ○ 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
- ○ 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

Medicaid Eligibility

☑ The age used for children with respect to 42 CFR 435.603(f)(3)(iv) is:

◉ Age 19

○ Age 19, or in the case of full-time students, age 21

PRA Disclosure Statement

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V.20140415

USE OF THE ALTERNATIVE SINGLE STREAMLINED APPLICATION ☐ Paper Application ☒ Online Application	
TRANSMITTAL NUMBER: 13-0008-MM	**STATE:** Hawaii
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.	

Medicaid Eligibility

State Name: Hawaii

OMB Control Number: 0938-1148

Transmittal Number: 16 - __ - 0001

Expiration date: 10/31/2014

General Eligibility Requirements
Eligibility Process

S94

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

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.

Application Date

1. First Name * | Middle Name | Last Name * | Suffix

2. Home address (If you are homeless, please enter that you are homeless with appropriate city, state and zip code)

Address Line 1 * | 3. Apartment or suite number

4. City * | 5. State * | 6. Zip code * | 7. County

Please provide a mailing address if different from your home address.

8. Mailing Address (leave blank if you don't have one)

Address Line 1 | 9. Apartment or suite number

10. City | 11. State | 12. Zip code | 13. County

14. Phone number | 15. Other phone number

16. Do you want to get information about this application by email? ○ Yes ○ No

Email Address *

17. Preferred Spoken Language | 18. Preferred Written Language

Enter The Other Preferred Spoken Language | Enter The Other Preferred Written Language

19. How many family members live with you?

20. Is any family member you usually live with incarcerated (detained or jailed) or residing in the Hawaii State Hospital? *

Family Member: First Name * | Middle Name | Last Name *

Start Date | Release Date

Remove

Family Member: First Name * | Middle Name | Last Name *

Start Date | Release Date

Add Family Member

Save & Exit | Next

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 ? * | 3. Date of birth (mm/dd/yyyy) * | 4. Gender *

5. Name of spouse if married

6. Social Security number (SSN)

7. Do you plan to file a federal income tax return NEXT YEAR? *

a. Will you jointly file with a spouse? *

Name of Spouse * | First Name * | Middle Name | Last Name

b. Will you claim any dependents on your tax return? *

Name of dependent * | First Name * | Middle Name | Last Name

Remove

Name of dependent * | First Name * | Middle Name | Last Name *

Add Dependent

c. Will you be claimed as a dependent on someone's tax return? *

Name of Tax Filer * | First Name * | Middle Name | Last Name *

☐ Check here if the tax filer that is claiming you as a dependent is not part of the household

How are you related to the tax filer?

8. Are you pregnant? *

How many babies are expected during this pregnancy? * | Expected Due Date *

9. Do you need health coverage? * ○ Yes ○ No

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 *

To

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 *

To *

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 *

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

Doc/Passport Expiration Date

Category Code

Country of Issuance

Other Document #

Visa Number

Document Description

Citizenship Certificate Number

Naturalization Certificate Number

14. Provide the date of entry to the U.S. found on your immigration document listed in Question 13.

a. Are you a citizen of the Federated States of Micronesia, Republic of the Marshall Islands, or Republic of Palau? *

(•) Yes ( ) No

Select Country of Citizenship *

b. Are you, or your spouse or parent a veteran or an active duty member of the US military?

15. Were you in foster care at age 18 or older in Hawaii?

16. Are you a full time student?

17. If Hispanic/Latino, ethnicity (OPTIONAL - 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 *

Employed 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 *

Wages/tips (before taxes) *

How Often ? *

Income Start Date

Income End Date

Add new Jobs

In the past year, did you:

Self Employed

If self-employed, answer the following questions

Type of work *

How much net income(profits once business expenses are paid) will you get paid from this self-employment this month? *

OTHER INCOME THIS MONTH

Income Type

Amount($)

How Often ?

Income Start Date

Income End Date

Remove

Income Type

Amount($)

How Often ?

Income Start Date

Income End Date

Add more income types

DEDUCTIONS

Type of deduction

Amount($)

How Often ?

Deduction Start Date

Deduction End Date

Remove

Type of deduction

Amount($)

How Often ?

Deduction Start Date

Deduction End Date

Add more deductions

YEARLY INCOME

Total income This year ($)

Total income next year(if different) ($)

Save & 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 | Last Name * | Suffix

2. Relationship to you * | 3. Date of birth (mm/dd/yyyy) * | 4. Gender *

5. Name of spouse if married

6. Social Security number (SSN)

7. Does PERSON 2 live at the same address as you?

Home Address (Leave blank if PERSON 2 do not have one)

Address Line 1 * | Apartment or suite number

City * | State * | Zip code * | County

Please provide a mailing address if different from your home address.

Mailing Address (leave blank if PERSON 2 doesn't have one)

Address Line 1 | Apartment or suite number

City | State | Zip code | County

8. Does PERSON 2 plan to file a federal income tax return NEXT YEAR? *

a. Will PERSON 2 file jointly with a spouse? *

Name of Spouse * — First Name * | Middle Name | Last Name *

b. Will PERSON 2 claim any dependents on their tax return? *

Name of dependent * — First Name * | Middle Name | Last Name *

Remove

Name of dependent * — First Name * | Middle Name | Last Name *

Add Dependent

c. Will PERSON 2 be claimed as a dependent on someone's tax return? *

Name of Tax Filer * — First Name * | Middle Name | Last Name *

☐ Check here if the person claiming PERSON 2 as a dependent is not part of the household

9. Is PERSON 2 pregnant? *

How many babies are expected during this pregnancy? * | Expected Due Date *

10. Does PERSON 2 need health coverage? * ○ Yes ○ No

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 *

To

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 *

To *

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? *

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

Doc/Passport Expiration Date

Category Code

Country of Issuance

Other Document #

Visa Number

Document Description

Citizenship Certificate Number

Naturalization Certificate Number

15. Provide the date of entry to the U.S. found on PERSON 2's immigration document listed in Question 14.

a. Is PERSON 2 a citizen of the Federated States of Micronesia, Republic of the Marshall Islands, or Republic of Palau? *

Yes No

Select Country of Citizenship *

b. Is PERSON 2 or their spouse or parent, a veteran or an active duty member of the U.S. military?

16. Was PERSON 2 in foster care at age 18 or older in Hawaii?

17. Is PERSON 2 a full-time student?

18. If Hispanic/Latino, ethnicity (OPTIONAL - 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

Type of Employment *

Employed 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 *

Wages/tips (before taxes) *

How Often ? *

Income Start Date

Income End Date

Add new Jobs

In the past year, did PERSON 2:

Self Employed

If self-employed, answer the following questions

Type of work *

How much net income(profits once business expenses are paid) will you get paid from this self-employment this month? *

OTHER INCOME THIS MONTH

Income Type

Amount($)

How Often ?

Income Start Date

Income End Date

Remove

Income Type

Amount($)

How Often ?

Income Start Date

Income End Date

Add more income types

DEDUCTIONS

Type of deduction

Amount($)

How Often ?

Deduction Start Date

Deduction End Date

Remove

Type of deduction

Amount($)

How Often ?

Deduction Start Date

Deduction End Date

Add more deductions

YEARLY INCOME

PERSON 2's total income this year? ($)

PERSON 2's total income next year (if you think it will be 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 Name | Last Name * | Suffix

2. Relationship to you * | 3. Date of birth (mm/dd/yyyy) * | 4. Gender *

5. Name of spouse if married

6. Social Security number (SSN)

7. Does PERSON 3 live at the same address as you? — No

Home Address (Leave blank if PERSON 3 do not have one)

Address Line 1 * | Apartment or suite number

City * | State * | Zip code * | County

Please provide a mailing address if different from your home address.

Mailing Address (leave blank if PERSON 3 doesn't have one)

Address Line 1 | Apartment or suite number

City | State | Zip code | County

8. Does PERSON 3 plan to file a federal income tax return NEXT YEAR? *

a. Will PERSON 3 file jointly with a spouse? *

Name of Spouse * — First Name * | Middle Name | Last Name *

b. Will PERSON 3 claim any dependents on their tax return? *

Name of dependent * — First Name * | Middle Name | Last Name *

Add Dependent

c. Will PERSON 3 be claimed as a dependent on someone's tax return? *

Name of Tax Filer * — First Name * | Middle Name | Last Name *

☐ Check here if the person claiming PERSON 3 as a dependent is not part of the household

How is PERSON 3 related to the tax filer?

9. Is PERSON 3 pregnant? *

How many babies are expected during this pregnancy? * | Expected Due Date *

10. Does PERSON 3 need health coverage? * ◯ Yes ◯ No

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 *

To

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 *

To *

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? *

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

Doc/Passport Expiration Date

Category Code

Country of Issuance

Other Document #

Visa Number

Document Description

Citizenship Certificate Number

Naturalization Certificate Number

15. Provide the date of entry to the U.S. found on PERSON 3's immigration document listed in Question 14.

a. Is PERSON 3 a citizen of the Federated States of Micronesia, Republic of the Marshall Islands, or Republic of Palau? *

Yes No

Select Country of Citizenship *

b. Is PERSON 3 or their spouse or parent, a veteran or an active duty member of the U.S. military?

16. Was PERSON 3 in foster care at age 18 or older in Hawaii?

17. Is PERSON 3 a full-time student?

18. If Hispanic/Latino, ethnicity (OPTIONAL - 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

Type of Employment *

Employed 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 * HI

Zip code *

Wages/tips (before taxes) *

How Often ? *

Income Start Date

Income End Date

Add new Jobs

In the past year, did PERSON 3:

Self Employed

If self-employed, answer the following questions

Type of work *

How much net income(profits once business expenses are paid) will you get paid from this self-employment this month? *

OTHER INCOME THIS MONTH

Income Type

Amount($)

How Often ?

Income Start Date

Income End Date

Remove

Income Type

Amount($)

How Often ?

Income Start Date

Income End Date

Add more income types

DEDUCTIONS

Type of deduction

Amount($)

How Often ?

Deduction Start Date

Deduction End Date

Remove

Type of deduction

Amount($)

How Often ?

Deduction Start Date

Deduction End Date

Add more deductions

YEARLY INCOME

PERSON 3's total income this year? ($)

PERSON 3's total income next year (if you think it will be different)? ($)

Remove Person | Add Person

Save & Exit | Back | 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 (mm/dd/yyyy) * | 4. Gender *

5. Name of spouse if married

6. Social Security number (SSN)

7. Does PERSON 4 live at the same address as you?

Home Address (Leave blank if PERSON 4 do not have one)

Address Line 1 * | Apartment or suite number

City * | State * | Zip code * | County

Please provide a mailing address if different from your home address.

Mailing Address (leave blank if PERSON 4 doesn't have one)

Address Line 1 | Apartment or suite number

City | State | Zip code | County

8. Does PERSON 4 plan to file a federal income tax return NEXT YEAR? *

a. Will PERSON 4 file jointly with a spouse? *

Name of Spouse * | First Name * | Middle Name | Last Name *

b. Will PERSON 4 claim any dependents on their tax return? *

Name of dependent * | First Name * | Middle Name | Last Name *

Remove

Name of dependent * | First Name * | Middle Name | Last Name *

Add Dependent

c. Will PERSON 4 be claimed as a dependent on someone's tax return? *

Name of Tax Filer * | First Name * | Middle Name | Last Name *

☐ Check here if the person claiming PERSON 4 as a dependent is not part of the household

How is PERSON 4 related to the tax filer?

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 *

To

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 *

To *

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? *

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

Doc/Passport Expiration Date

Category Code

Country of Issuance

Other Document #

Visa Number

Document Description

Citizenship Certificate Number

Naturalization Certificate Number

15. Provide the date of entry to the U.S. found on PERSON 4's immigration document listed in Question 14.

a. Is PERSON 4 a citizen of the Federated States of Micronesia, Republic of the Marshall Islands, or Republic of Palau? *

Yes No

Select Country of Citizenship *

b. Is PERSON 4 or their spouse or parent, a veteran or an active duty member of the U.S. military?

16. Was PERSON 4 in foster care at age 18 or older in Hawaii?

17. Is PERSON 4 a full-time student?

18. If Hispanic/Latino, ethnicity (OPTIONAL - 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

Type of Employment *

Employed 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 *

Wages/tips (before taxes) *

How Often ? *

Income Start Date

Income End Date

Add new Jobs

In the past year, did PERSON 4:

Self Employed

If self-employed, answer the following questions

Type of work *

How much net income(profits once business expenses are paid) will you get paid from this self-employment this month? *

OTHER INCOME THIS MONTH

Income Type

Amount($)

How Often ?

Income Start Date

Income End Date

Remove

Income Type

Amount($)

How Often ?

Income Start Date

Income End Date

Add more income types

DEDUCTIONS

Type of deduction

Amount($)

How Often ?

Deduction Start Date

Deduction End Date

Remove

Type of deduction

Amount($)

How Often ?

Deduction Start Date

Deduction End Date

Add more deductions

YEARLY INCOME

PERSON 4's total income this year? ($)

PERSON 4's total income next year (if you think it will be different)? ($)

Remove Person | Add Person

Save & Exit | Back | Next

First Name	Middle Name	Last Name	Gender	Date Of Birth	Define Relationships
					Self

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 *

Save & Exit | Back | Next

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?** * ○ Yes ○ No

Will file jointly with a spouse?

	First Name	Middle Name	Last Name	Suffix
☐				
☐				
☐				

Will claim any dependents on their tax return?

	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
☐				
☐				
☐				

☐ Check here if the tax filer claiming as a dependent is not part of the household.

How is related to the tax filer?

Does **plan to file a federal income tax return NEXT YEAR?** * ○ Yes ○ No

Will file jointly with a spouse?

	First Name	Middle Name	Last Name	Suffix
☐				
☐				
☐				

Will claim any dependents on their tax return?

	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
☐				
☐				
☐				

☐ Check here if the tax filer claiming as a dependent is not part of the household.

How is related to the tax filer?

Does plan to file a federal income tax return NEXT YEAR? * ○ Yes ○ No

Will file jointly with a spouse?

	First Name	Middle Name	Last Name	Suffix
☐				
☐				
☐				

Will claim any dependents on their tax return?

	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
☐				
☐				
☐				

☐ Check here if the tax filer claiming as a dependent is not part of the household.

How is related to the tax filer?

Does plan to file a federal income tax return NEXT YEAR? * ○ Yes ○ No

Will file jointly with a spouse?

	First Name	Middle Name	Last Name	Suffix
☐				
☐				
☐				

Will claim any dependents on their tax return?

	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
☐				
☐				
☐				

☐ Check here if the tax filer claiming as a dependent is not part of the household.

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 Hospital? * ○ Yes ○ No

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.

Is enrolled in health coverage now? * ○ Yes ○ No

Coverage Details

Type of Coverage(s) *

Policy Name *

Policy Number

Policy Start Date *

Policy End Date

Includes medical care? ○ Yes ○ No

Includes dental care? ○ Yes ○ No

Includes vision care? ○ Yes ○ No

Is this a limited-benefit plan, like a school accident policy? ○ Yes ○ No

Add Coverage

Coverage Details

Type of Coverage(s) *

Policy Name *

Policy Number

Policy Start Date *

Policy End Date

Includes medical care? ○ Yes ○ No

Includes dental care? ○ Yes ○ No

Includes vision care? ○ Yes ○ No

Is this a limited-benefit plan, like a school accident policy? ○ Yes ○ No

Remove Coverage

Is enrolled in health coverage now? * ○ Yes ○ No

Is enrolled in health coverage now? * ○ Yes ○ No

Is enrolled in health coverage now? * ○ 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. Next

☐ Yes. If yes, answer the following questions.

Is this a state employee benefit plan? * ○ Yes ○ 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
○			
○			
○			
○			

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? *

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? * ○ Yes ○ No

12a. If you're in a waiting or probationary period, when can you enroll in coverage? *

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? * ◯ Yes ◯ 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) *

Remove Employer | Add Employer

Save & Exit | Back | Next

American Indian or Alaskan Native Family Member (AI/AN)

Are you or anyone in your family American Indian or Alaskan Native? *

☐ No. No one in my family is American Indian or Alaskan Native. Next

☐ Yes. If yes, answer the following questions.

Is an American Indian or Alaskan Native? * ○ Yes ○ No

Is a member of a Federally recognized Tribe ? *

○ Yes ○ No

If yes, Tribe name is *

Has 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. *

○ Yes ○ No

Is eligible to get services from the Indian Health Service, tribal health programs, or 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:

- 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 reservations)
- Money from selling things that have cultural significance

Amount ($): How often?

Is an American Indian or Alaskan Native? * ○ Yes ○ No

Is an American Indian or Alaskan Native? * ○ Yes ○ No

Is an American Indian or Alaskan Native? * ○ Yes ○ No

Save & Exit Back Next

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. Next
- [ ] 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

Phone Number *

Organization Name | ID Number (If applicable)

Save & Exit | Back | Next

Read & 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 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 mybenefits.hawaii.gov or call 1-800-316-8005 (TTY: Oahu 808-692-7182 or NI 1-800-603-1201) or visit www.Healthcare.gov 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 Conditions *

Primary Applicant First Name *

Primary Applicant Last Name *

Save & Exit | Back | Review

State of Hawaii, Department of Human Services

Federal Health Insurance Marketplace

Application For Health Coverage & Help Paying Costs

THINGS TO KNOW

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 mybenefits.hawaii.gov.
- If you want to purchase insurance without help, apply directly at www.healthcare.gov.

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.

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.

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 mybenefits.hawaii.gov 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**: mybenefits.hawaii.gov
- **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 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.

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** 
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 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.

Please print using black or dark ink only.
Mark each box [☐] as appropriate, with an "X", like this → ☒.

STEP 1 Tell Us About Yourself.

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

1. First name	Middle name	Last name	Suffix

2. Home address (If you are homeless, please enter "homeless" here with appropriate city, state and zip code)			3. Apartment or suite number
4. City	5. State	6. ZIP code	7. County
8. Mailing address (if different from home address)			9. Apartment or suite number
10. City	11. State	12. ZIP code	13. County
14. Phone number ( ) –		15. Other phone number ( ) –	

16. Do you want to get information about this application by email? ☐ **Yes** ☐ **No**
Email address:

17. What is your preferred spoken language (if not English)?	18. What is your preferred written language (if not English)?
19. How many family members live with you?	20. Is any family member you usually live with incarcerated (detained or jailed) or residing in the Hawaii State Hospital? ☐ **Yes** ☐ **No** **If yes**, please list their name(s):

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 pages 4 and 5 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 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.

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 name	Suffix	2. Relationship to PERSON 1? **SELF**

3. Date of birth (mm/dd/yyyy) ☐☐/☐☐/☐☐☐☐	4. Gender: ☐ Male ☐ Female	5. Name of spouse if married.

6. Social Security Number (SSN) ☐☐☐-☐☐-☐☐☐☐

We need this if you want health coverage and have an SSN. Providing your SSN can be helpful if you do not want health coverage too since it can speed up the application process. We use SSNs to check income and other information to see who is eligible for help with health coverage costs. If someone wants help getting an SSN, call 1-800-772-1213 or visit **socialsecurity.gov**. TTY users should call 1-800-325-0778.

7. Do you plan to file a federal income tax return NEXT YEAR?
(You can still apply for health insurance even if you do not file a federal income tax return.)

☐ **Yes. If yes,** please answer questions a–c. ☐ **No. If no,** skip to question c.

a. Will you file jointly with a spouse? ☐ **Yes** ☐ **No**
If yes, write name of spouse: _____

b. Will you claim any dependents on your tax return? ☐ **Yes** ☐ **No**
If yes, write name(s) of dependents: _____

c. Will you be claimed as a dependent on someone's tax return? ☐ **Yes** ☐ **No**
If yes, write the name of the tax filer: _____
How are you related to the tax filer? _____

8. Are you pregnant? ☐ **Yes** ☐ **No If yes,** how many babies are expected during this pregnancy? ____ Expected Due Date: _____

9. Do you need health coverage? (Even if you have insurance, there 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 3. ➡
Leave the rest of this page blank.

10. Do you have a disability that will last more than twelve (12) months? ☐ **Yes** ☐ **No**

a. Do you currently receive long term care nursing services: ☐ **Yes**, in a nursing facility ☐ **Yes**, in my home in the community ☐ **No**

b. Have you received long term care nursing services in the last three (3) months?
☐ **Yes. If yes**, what dates(s)? _____ ☐ **No**

c. Do you think you need long term care nursing services now? ☐ **Yes** ☐ **No**

d. Do you receive Supplemental Security Income (SSI)? ☐ **Yes** ☐ **No**

11. Did you receive any medical services in the past ten (10) calendar days immediately prior to the date of this application?
☐ **Yes. If yes**, what date(s)? ☐ **No**

12. Are you a U.S. citizen or U.S. national? ☐ **Yes. If yes,** skip to Question 15. ☐ **No**

13. If you are not a U.S. citizen or U.S. national, do you have eligible immigration status? **If Yes**, enter document type and ID number.

Immigration document type (i.e. I-551, Visa, etc.)	Status type (optional)	Write your name as it appears on your immigration document
Alien or I-94 number		Passport number or other card number
SEVIS ID or Expiration Date (optional)		Other (category code or country of issuance)

14. Provide the date of entry to the U.S. found on your immigration document listed in question 13. (mm/dd/yyyy) _____

a. Are you a citizen of the ☐ Federated States of Micronesia, ☐ Republic of Marshall Islands, or ☐ Republic of Palau?
☐ **Yes** ☐ **No**

b. Are you, your spouse or parent, a veteran or an active-duty member of the U.S. military? ☐ **Yes** ☐ **No**

15. Were you in foster care at age 18 years or older in Hawaii? ☐ **Yes** ☐ **No**

16. Are you a full-time student? ☐ **Yes** ☐ **No**

17. If Hispanic/Latino, ethnicity (**OPTIONAL**: mark all that apply.)
☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other _____

18. Race (**OPTIONAL**: mark all that apply)

☐ White	☐ Black or African American	☐ Filipino	☐ Vietnamese	☐ Guamanian or Chamorro
☐ Asian Indian	☐ American Indian or Alaska Native	☐ Japanese	☐ Other Asian	☐ Other Pacific Islander
☐ Chinese	☐ Native Hawaiian	☐ Korean	☐ Samoan	☐ Other:

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.

STEP 2: PERSON 1 (Continue With Yourself)

Current Job & Income Information

☐ **Employed**
If you are currently employed, tell us about your income. Start with question 19.

☐ **Self-employed**
Skip to question 28.

☐ **Not employed**
Skip to question 29.

CURRENT JOB 1:

Start Date: **End Date:**

19. Employer name and address:

20. Employer phone number:
( ) –

21. Wages/tips (before taxes): ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly

$_____

22. Average hours worked each WEEK:

CURRENT JOB 2: (If you have more jobs and need more space, attach another sheet of paper.)

Start Date: **End Date:**

23. Employer name and address:

24. Employer phone number:
( ) –

25. Wages/tips (before taxes): ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly

$_____

26. Average hours worked each WEEK:

27. Did you: ☐ Change jobs ☐ Stop working ☐ Start working fewer hours ☐ None of these

28. If self-employed, answer the following questions:
a. Type of work:
b. How much net income (profit once business expenses are paid) will you get from 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 do not need to tell us about child support or veteran's payment.

☐ Unemployment $_____ How often? _____
☐ Pensions $_____ How often? _____
☐ Social Security $_____ How often? _____
☐ Retirement accounts $_____ How often? _____
☐ Alimony received $_____ How often? _____
☐ Net farming/fishing $_____ How often? _____
☐ Net rental/royalty $_____ How often? _____
☐ Other income $_____ How often? _____
Type of other income: _____

30. **DEDUCTIONS:** Check all that apply, and give the amount and how often you get it.
If you pay for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower.
NOTE: You should not include a cost that you already considered in your answer to net self-employment (question 28b)

☐ Alimony paid $_____ How often? _____
☐ Student loan interest $_____ How often? _____
☐ Other deductions $_____ How often? _____
Type of other deductions: _____

31. **NET YEARLY INCOME:** Complete if your net income changes a lot from month to month.
If you do not expect changes to your monthly income, skip to the next person.

Your total income this year:	Your total income next year (if you think it will be different)
$	$

THANKS! This is all we need to know about you.

If there are 2 or more people to include, please make a copy of STEP 2: PERSON 2 (Pages 4 and 5).
Once completed, attach additional pages 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.

STEP 2: PERSON 2

Complete Step 2 for additional household members other than PERSON 1.

1. First name	Middle name	Last name	Suffix	2. Relationship to PERSON 1?

3. Date of birth (mm/dd/yyyy) ☐☐/☐☐/☐☐☐☐	4. Gender: ☐ Male ☐ Female	5. Name of spouse if married.

6. Social Security Number (SSN) ☐☐☐-☐☐-☐☐☐☐

We need this if PERSON 2 wants health coverage and has an SSN. Providing your SSN can be helpful if you do not want health coverage too since it can speed up the application process. We use SSNs to check income and other information to see who is eligible for help with health coverage costs.

7. Does PERSON 2 live at the same address as PERSON 1? ☐ **Yes** ☐ **No**
If no, write address: _____

8. Does PERSON 2 plan to file a federal income tax return NEXT YEAR?
(You can still apply for health insurance even if you do not file a federal income tax return.)

☐ **Yes If yes,** please answer questions a–c. ☐ **No. If no,** skip to question c.

a. Will PERSON 2 file jointly with a spouse? ☐ **Yes** ☐ **No**
If yes, write name of spouse: _____

b. Will PERSON 2 claim any dependents on his/her tax return? ☐ **Yes** ☐ **No**
If yes, write name(s) of dependents: _____

c. Will PERSON 2 be claimed as a dependent on someone's tax return ☐ **Yes** ☐ **No**
If yes, write the name of the tax filer: _____
How is PERSON 2 related to the tax filer? _____

9. Is PERSON 2 pregnant? ☐ **Yes** ☐ **No If yes,** how many babies are expected during this pregnancy? _____ Expected Due Date: _____

10. Does PERSON 2 need health coverage? (Even if you have insurance, there 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.

11. 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 a nursing facility ☐ **Yes**, in my home in the community ☐ **No**
b. Has PERSON 2 received long term care nursing services in the last three (3) months? ☐ **Yes. If yes**, what date(s)? _____ ☐ **No**
c. Does PERSON 2 think you need long term care nursing services now? ☐ **Yes** ☐ **No**
d. Does PERSON 2 receive Supplemental Security Income (SSI)? ☐ **Yes** ☐ **No**

12. 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)? ☐ **No**

13. Is PERSON 2 a U.S. citizen or U.S. national? ☐ **Yes. If yes,** skip to Question 16. ☐ **No**

14. If PERSON 2 is not a U.S. citizen or U.S. national, does he/she have eligible immigration status?
☐ **If Yes**, enter document type and ID number.

Immigration document type (i.e. I-551, Visa, etc.)	Status type (optional)	Write your name as it appears on your immigration document
Alien or I-94 number		Passport number or other card number
SEVIS ID or Expiration Date (Optional)		Other (category code or country of issuance)

15. Provide the date of entry to the U. S. found on your immigration document listed in question 14. (mm/dd/yyyy) _____
a. Is PERSON 2 a citizen of the ☐ Federated States of Micronesia, ☐ Republic of Marshall Islands, or ☐ Republic of Palau?
☐ **Yes** ☐ **No**
b. Is PERSON 2, PERSON 2's spouse or parent, a veteran or an active-duty member of the U.S. military? ☐ **Yes** ☐ **No**

16. Was PERSON 2 in foster care at age 18 years or older in Hawaii? ☐ **Yes** ☐ **No**

17. Is PERSON 2 a full-time student? ☐ **Yes** ☐ **No**

18. If Hispanic/Latino, ethnicity (**OPTIONAL**: mark all that apply.)
☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other _____

19. Race (**OPTIONAL**: mark all that apply)

☐ White	☐ Black or African American	☐ Filipino	☐ Vietnamese	☐ Guamanian or Chamorro
☐ Asian Indian	☐ American Indian or Alaska Native	☐ Japanese	☐ Other Asian	☐ Other Pacific Islander
☐ Chinese	☐ Native Hawaiian	☐ Korean	☐ Samoan	☐ Other:

Now, tell us about any income from PERSON 2 on the back.

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STEP 2: PERSON 2

Current Job & Income Information

☐ **Employed**
If PERSON 2 is currently employed, tell us about his/her income. Start with question 20.

☐ **Self-employed**
Skip to question 29.

☐ **Not employed**
Skip to question 30.

CURRENT JOB 1:

Start Date: **End Date:**

20. Employer name and address:

21. Employer phone number:
( ) –

22. Wages/tips (before taxes): ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly

$_____

23. Average hours worked each WEEK:

CURRENT JOB 2: (If PERSON 2 has more jobs and need more space, attach another sheet of paper.)

Start Date: **End Date:**

24. Employer name and address:

25. Employer phone number:
( ) –

26. Wages/tips (before taxes): ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly

$_____

27. Average hours worked each WEEK:

28. Did PERSON 2: ☐ Change jobs ☐ Stop working ☐ Start working fewer hours ☐ None of these

29. If PERSON 2 is self-employed, answer the following questions:

a. Type of work:

b. How much net income (profit once business expenses are paid) will PERSON 2 get from this self-employment this month?

$_____

30. **OTHER INCOME THIS MONTH:** Check all that apply, and give the amount and how often PERSON 2 gets it.
NOTE: You do not need to tell us about child support or veteran's payment.

☐ Unemployment $_____ How often? _____
☐ Pensions $_____ How often? _____
☐ Social Security $_____ How often? _____
☐ Retirement accounts $_____ How often? _____
☐ Alimony received $_____ How often? _____
☐ Net farming/fishing $_____ How often? _____
☐ Net rental/royalty $_____ How often? _____
☐ Other income $_____ How often? _____
Type of other income: _____

31. **DEDUCTIONS:** Check all that apply, and give the amount and how often PERSON 2 gets 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 of health coverage a little lower.
NOTE: You should not include a cost that you already considered in your answer to net self-employment (question 29b)

☐ Alimony paid $_____ How often? _____
☐ Student loan interest $_____ How often? _____
☐ Other deductions $_____ How often? _____
Type of other deductions: _____

32. **NET YEARLY INCOME:** Complete if PERSON 2's net income changes a lot from month to month.
If you do not except changes to PERSON 2's 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.

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STEP 3 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.

- Married
- Parent (including step)
- Grandparent
- Uncle/Aunt
- Under Primary Care
- Child (including step)
- Grandchild
- Cousin
- Sibling (including step)
- Foster Parent
- Not Related
- Unmarried Partner
- Niece/Nephew (including step)
- Foster Child

Household Member PERSON 1

Name of Person 1:	Primary Individual	SELF

Household Member PERSON 2

Name of Person 2:	Relationship to Person 1:
Is Person 2 primarily responsible for the care of a child(ren) under age 19 years old in this household?	☐ **Yes**, name of child(ren): _____ ☐ **No**

Household Member PERSON 3

Name of Person 3:	Relationship to Person 1:	Relationship to Person 2:
Is Person 3 primarily responsible for the care of a child(ren) under age 19 years old in this household?	☐ **Yes**, name of child(ren): _____ ☐ **No**	

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 of child(ren): _____ ☐ **No**		

Household Member PERSON 5

Name of Person 5:	Relationship to Person 1:	Relationship to Person 2:	Relationship to Person 3:
Relationship to Person 4:			
Is Person 5 primarily responsible for the care of a child(ren) under age 19 years old in this household?	☐ **Yes**, name of child(ren): _____ ☐ **No**		

Household Member PERSON 6

Name of Person 6:	Relationship to 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 child(ren) under age 19 years old in this household?	☐ **Yes**, name of child(ren): _____ ☐ **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.

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STEP 4 American Indian Or Alaska Native (AI/AN) Family Member(s)

1. **Are you or is anyone in your family American Indian or Alaska Native?**

☐ **Yes. If yes,** go to Appendix B.

☐ **No. If No,** skip to Step 5.

STEP 5 Your Family's Health Coverage

1. 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?

☐ **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.**

☐ **No**

2. 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**

3. Was anyone on this application found not eligible for Medicaid or CHIP due to their immigration status since October 1, 2013?

☐ **Yes Who:** _____

☐ **No**

4. Did anyone on this application apply for coverage during the Marketplace open enrollment period?

☐ **Yes Who:** _____

☐ **No**

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 parent or spouse, even if they do not accept the coverage.

☐ **Yes Continue and then complete Appendix A. Is this a state employee benefit plan?** ☐ **Yes** ☐ **No**

☐ **No**

6. Is anyone enrolled in health coverage now?

☐ **Yes If yes**, continue to question 7 (*Information about current health coverage)*.

☐ **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, m*ake a copy of the next page (page 8), begin with PERSON 2 and attach to this application.)*

Family Health Coverage PERSON 1

Name of person 1 enrolled in health coverage:	
Type of Coverage(s): ☐ Employer Insurance ☐ COBRA ☐ Medicaid ☐ CHIP ☐ Medicare ☐ TRICARE ☐ VA health care program ☐ Peace Corps ☐ Other	
If it is an employer insurance: *(You will also need to complete Appendix A.)* Name of health insurance company:	Policy/ID number
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? ☐ **Yes** ☐ **No**	☐ Includes Medical? ☐ Includes Dental? ☐ Includes Vision?

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Family Health Coverage PERSON 2

Name of person 2 enrolled in health coverage:

Type of Coverage(s): ☐ Employer Insurance ☐ COBRA ☐ Medicaid ☐ CHIP ☐ Medicare ☐ TRICARE ☐ VA health care program ☐ Peace Corps ☐ Other

If it is an employer insurance: *(You will also need to complete Appendix A.)*
Name of health insurance company:
Policy/ID number

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? ☐ **Yes** ☐ **No** ☐ Includes Medical? ☐ Includes Dental? ☐ Includes Vision?

Family Health Coverage PERSON 3

Name of person 3 enrolled in health coverage:

Type of Coverage(s): ☐ Employer Insurance ☐ COBRA ☐ Medicaid ☐ CHIP ☐ Medicare ☐ TRICARE ☐ VA health care program ☐ Peace Corps ☐ Other

If it is an employer insurance: *(You will also need to complete Appendix A.)*
Name of health insurance company:
Policy/ID number

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? ☐ **Yes** ☐ **No** ☐ Includes Medical? ☐ Includes Dental? ☐ Includes Vision?

Family Health Coverage PERSON 4

Name of person 4 enrolled in health coverage:

Type of Coverage(s): ☐ Employer Insurance ☐ COBRA ☐ Medicaid ☐ CHIP ☐ Medicare ☐ TRICARE ☐ VA health care program ☐ Peace Corps ☐ Other

If it is an employer insurance: *(You will also need to complete Appendix A.)*
Name of health insurance company:
Policy/ID number

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? ☐ **Yes** ☐ **No** ☐ Includes Medical? ☐ Includes Dental? ☐ Includes Vision?

Family Health Coverage PERSON 5

Name of person 5 enrolled in health coverage:

Type of Coverage(s): ☐ Employer Insurance ☐ COBRA ☐ Medicaid ☐ CHIP ☐ Medicare ☐ TRICARE ☐ VA health care program ☐ Peace Corps ☐ Other

If it is an employer insurance: *(You will also need to complete Appendix A.)*
Name of health insurance company:
Policy/ID number

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? ☐ **Yes** ☐ **No** ☐ Includes Medical? ☐ Includes Dental? ☐ Includes Vision?

Family Health Coverage PERSON 6

Name of person 6 enrolled in health coverage:

Type of Coverage(s): ☐ Employer Insurance ☐ COBRA ☐ Medicaid ☐ CHIP ☐ Medicare ☐ TRICARE ☐ VA health care program ☐ Peace Corps ☐ Other

If it is an employer insurance: *(You will also need to complete Appendix A.)*
Name of health insurance company:
Policy/ID number

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? ☐ **Yes** ☐ **No** ☐ Includes Medical? ☐ Includes Dental? ☐ Includes Vision?

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!!!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 **mybenefits.hawaii.gov** or call **1-877-628-5076** (TTY/TDD: 1-855-585-8604) or visit **www.healthcare.gov** 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 years ☐ 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
Kapolei Unit
P.O. Box 29920
Honolulu, HI 96820-2320

MQD/EB
East Hawaii Section
1404 Kilauea Avenue
Hilo, HI 96720-4670

MQD/EB
West Hawaii Section
Lanihau Professional Center
75-5591 Palani Road, Suite 3004
Kailua-Kona, HI 96740-3633

MQD/EB
Lanai Unit
P.O. Box 1619
Kaunakakai, HI 96748-1619

MQD/EB
Maui Section
Millyard Plaza
210 Imi Kala Street, Suite 101
Wailuku, HI 96793-1274

MQD/EB
Molokai Unit
P.O. Box 1619
Kaunakakai, HI 96748-1619

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**

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APPENDIX A

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 Information

Ask the employer for this section.

3. Employer name		4. Employer Identification Number (EIN)
5. Employer address (notice will be sent to this 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. Are you currently eligible for coverage offered by this employer, or will you become eligible in the next three (3) months?

☐ **Yes** (continue)

a. If you are in a waiting or probationary period, when can you enroll in coverage? _____ mm/dd/yyyy

List the names of anyone else who is eligible for 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. Does the employer offer a health plan that meets the minimum value standard*?

☐ **Yes** ☐ **No**

15. For the lowest-cost plan that meets the minimum value standard* offered only to the employee (do not include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/she received the maximum discount for any tobacco cessation program, and did not receive any other discounts based on wellness programs.

a. How much would the employee have to pay in premiums for this plan? $ _____

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Once a month ☐ 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

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 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

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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.

EMPLOYEE Information

The employee needs to fill out this section.

1. Employee name (First, Middle, Last)	2. Employee Social Security Number ☐☐☐-☐☐-☐☐☐☐

EMPLOYER Information

Ask the employer for this section.

3. Employer name		4. Employer Identification Number (EIN)
5. Employer address (notice will be sent to this address)		6. Employer phone number ( ) –
7. City	8. State	9. ZIP Code

10. Who can we contact about employee health coverage at this job?

11. Phone number (if different from above) ( ) –	12. Email address

13. Are you currently eligible for coverage offered by this employer, or will you become eligible in the next three (3) months?

☐ **Yes** (continue)

a. 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/yyyy (continue)

☐ **No** (**STOP** and go to Step 6 in the application)

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)

☐ **No**

(Go to question 14)

14. Does the employer offer a health plan that meets the minimum value standard*?

☐ **Yes** ☐ **No**

15. For the lowest-cost plan that meets the minimum value standard* offered only to the employee (do not include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/she received the maximum discount for any tobacco cessation program, and did not receive any other discounts based on wellness programs.

a. How much would the employee have to pay in premiums for this plan? $_____

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Once a month ☐ 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

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 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

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APPENDIX B

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 Last	First Middle 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**
4. 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: • 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 reservations). • Money from selling things that have cultural significance.	$_____ How often?_____	$_____ How often?_____

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APPENDIX C

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 ( ) –			
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 Individual's Signature	12. Date (mm/dd/yyyy)

Authorized Representative

As the designated Authorized Representative, by signing below I agree to maintain the confidentiality of any information provided to me by the Department or it's designee and I can be released as the Authorized Representative:

Signature of Authorized Representative _____ Telephone _____ Date _____

Mailing Address _____ City _____ State _____ ZIP Code _____

As applicable, I _____, am a provider or staff member or volunteer
PRINT Name of Individual

of an organization: _____
PRINT Name of Provider/Organization

I understand and agree, as a condition of serving as the Authorized Representative, I will adhere to the regulations relating to confidentiality of information and the prohibition against reassignment of provider claims as appropriate for a health facility or an organization acting on the facility's behalf, as well as other relevant State and Federal laws covering conflicts of interest and confidentiality of information.

For certified application counselors, navigators, agents, and brokers only

Complete this section if you are a certified application counselor, navigator, agent, or broker filling out this application for someone else.

1. Application start date (mm/dd/yyyy)	
2. First name, Middle name, Last name, & Suffix	
3. Organization name	4. ID number (if applicable)

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.

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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

I. Aged, blind, and disabled recipients of optional State supplementary 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:

A. Regular, in cash, and based on need;

B. Available on a Statewide basis;

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

D. Equal to the difference between income and the financial standard used to determine eligibility for the supplement.

II. There are variations in the payment levels by political subdivisions.

☒ No.

☐ Yes, as described below:

State of HAWAII

2. The method(s) checked below is used in handling resources in excess of those specified above:

☐ Excess non-income producing property (except the home) must be disposed of

☒ Any excess resources render the individual ineligible

☐ Other, described as follows:

DHEW Trans. No. MCAS 80-18
Trans. Date Dec 22 1980
DHEW Approval FEB 09 1981