State of Hawaii
Department of Human Services

Med-QUEST Division

FOR DEPARTMENT USE ONLY		
Case Name	**Case Number**	**Date Request Received:**
Unit Worker Name:	**Unit**	(Check One) ☐TEL ☐PER ☐MAIL ☐OTH

REQUEST FOR A HEARING

I. I _____ am requesting a hearing for the following reasons:

(Print Applicant/Beneficiary First and Last Name)

A. **I DO NOT AGREE** with the action taken by the Med-QUEST Unit/Office.

- ☐ 1. My application was denied.
- ☐ 2. My redetermination for continued medical assistance was terminated.
- ☐ 3. Assessment of a spenddown, cost share, or enrollment fee.
- ☐ 4. Change in spenddown, cost share or enrollment fee amount.
- ☐ 5. Other (Specify) _____

Explain item(s) checked above _____

_____

(Continue on the back of this form if you need more space)

B. **I DO NOT AGREE** with the action taken by the managed care health plan.

- ☐ 1. My coverage or service was denied or terminated.
- ☐ 2. Other (Specify) _____

Explain item(s) checked above: _____

_____

(Continue on the back of this form if you need more space)

II. A beneficiary may request for Aid Paid Pending and benefits may be restored while you wait for a hearing decision if:

A. Item I-A2-A5 as a beneficiary was selected above and this form received by the Med-QUEST office within 15 calendar days from the date of the adverse notice; or

B. Item I-B was selected above and this form received by the Med-QUEST office within 10 calendar days from the date of the adverse notice; and

C. Select one option below. *(If you do not make a selection, you will not automatically receive Aid Paid Pending.)*

- ☐ Yes. I want my benefits restored while waiting for a hearing decision and acknowledge that if the hearing decision is in favor of the Department or if I decide to withdraw or abandon my request for a hearing before a decision is made, I must repay all medical assistance or coverage I received for this period.
- ☐ No. I do not want my benefits restored.

III. Optional Designation of Authorized Representative:

I give my permission to _____ **to be my Authorized Representative**

Print name of Authorized Representative

to represent me and act for me in the Hearing.

_____

(Print Applicant/Beneficiary Name) (Applicant/Beneficiary's Signature) (Date) (Mailing Address)

_____

Authorized Representative Signature (Date) (Mailing Address)

IF AN AUTHORIZED REPRESENTATIVE IS SIGNING ON BEHALF OF AN APPLICANT/BENEFICIARY, THEY MUST ATTACH A COPY OF THE POWER OF ATTORNEY, GUARDIANSHIP DOCUMENT, A COMPLETED DHS 1121- "DESIGNATION OR REVOCATION OF AN AUTHORIZED REPRESENTATIVE" FORM OR DHS 1121A-"AGREEMENT TO ACT AS AN AUTHORIZED REPRESENTATIVE" FORM TO THIS SUBMISSION.

FORM PURPOSE

The DHS 1161 "Request for A Hearing" form may be used by the applicant or beneficiary to request a hearing. An applicant or beneficiary may also request a hearing through telephone, mail, in-person, or other commonly available electronic means.

FORM INSTRUCTIONS

Section I.
If an Authorized Representative is assisting an Applicant/Beneficiary with the completion of this form the Authorized Representative shall read the instructions in Section III.

1. Print Applicant/Beneficiary First and Last Name.
2. Applicant/Beneficiary/Authorized Representative to check appropriate box and explain.

Section II.A. and Section II.B.
Applicant/Beneficiary or Authorized Representative is being informed when Aid Paid Pending may be restored based upon when the request was received.

Section II.C:
The beneficiary who:

- Selects "Yes" shall have his/her benefits restored under Aid Paid Pending a hearing decision.
- Selects "No" shall not have his/her benefits restored under Aid Paid Pending a hearing decision.
- Does not select either option, will automatically have his/her benefits restored under Aid Paid Pending a hearing decision.

Section III: If the applicant or beneficiary wishes to designate an Authorized Representative, print name of Authorized Representative. The Applicant/Beneficiary shall print their name, sign, date, and print their full mailing address. The Authorized Representative, shall sign, date, and print their mailing address.

The Authorized Representative will need to attach a copy of verification of the Power of Attorney, Guardian, Surrogacy form DHS 1121A or a completed DHS 1121 Designate Authorized Representative Form signed by the individual with the submission of the DHS 1161.

Upon completion of this form, return the original and a copy of the document authorizing you to be a representative to your assigned eligibility worker. You may also contact Customer Service at 524-3370 or for your neighbor islands 1-800-316-8005, (TTY/TDD 711) for additional information. You may keep a copy of this form for your records.