

INSTRUCTIONS

DHS 1100A (Rev. 09/13)

APPLICATION FOR HEALTH COVERAGE & HELP PAYING COSTS (SHORT FORM)

PURPOSE:

The DHS 1100A, APPLICATION FOR HEALTH COVERAGE & HELP PAYING COSTS (SHORT FORM) (Rev. 09/13) shall be used as the Departmental application for adults without dependents or children receiving foster care maintenance payments, adoption assistance, and kinship guardianship assistance applying for medical assistance.

GENERAL INSTRUCTIONS:

1. An individual shall complete the DHS 1100A when applying for medical assistance. The DHS 1100A shall be completed and signed by an applicant who is an adult or a responsible household member. If the applicant is a minor, is incapacitated and incapable of acting on his or her own behalf, or is deceased, persons who may apply on behalf of the applicant includes the applicant/recipient's guardian, conservator, or executor, a person who knows of the applicant's need to apply, a representative of a public agency, or other responsible and concerned persons.

2. The Department:
 - a) Shall provide assistance to any applicant with the DHS 1100A in person, over the telephone, and online, in a manner that is accessible to individuals with disabilities and those who are limited English proficient, in accordance with the Disabilities Act and by section 504 of the Rehabilitation Act and Title VI of the Civil Rights Act of 1964.

 - b) May choose to designate organizations, subject to certification by the department or designee to provide assistance to an applicant with the application process, to include but not be limited to:
 - Completion or submission of the DHS 1100A for medical assistance.
 - Interaction with the department on the status of the application.
 - Assistance with responses to the Department; and
 - Case management following the initial approval and subsequent redeterminations in compliance with federal requirements.

 - c) Shall establish for department-certified application counselors providing assistance to an applicant:
 - 1) A designated web portal for purposes of providing assistance under HAR §17-1711.1-11;
 - 2) A secure mechanism to ensure they are able to perform only those duties for which they are certified; and
 - 3) Procedures to ensure that an applicant is:
 - Informed of the functions and responsibilities of the certified application counselor;
 - Able to authorize a certified application counselor to receive confidential information regarding the applicant related to the application; and

- Informed that services provided by the certified application counselor is provided free of charge.

3. The DHS 1100A may be submitted to the Department by one of the following methods:
- Via the Department's designated internet web site(s);
 - By telephone;
 - Via the United States Postal Service;
 - In person; or
 - Through other commonly available electronic means.

NOTE: An applicant who is unable to complete the entire application must provide his/her name, address, and a signature of the applicant or authorized representative.

Additional information as determined by the Department may be requested when coverage for long-term care services is requested.

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STEP 1 Tell us about yourself.

A responsible household member shall complete the DHS 1100A by providing the following information as requested:

- | | | |
|-----|--|---|
| 1. | First name, Middle name, Last name, & Suffix | Enter first, middle, last name, & suffix |
| 2. | Home address (Leave blank if you don't have one.) | Enter home address |
| 3. | Apartment or suite number | Enter apartment or suite number. |
| 4. | City | Enter city |
| 5. | State | Enter state |
| 6. | ZIP code | Enter ZIP code |
| 7. | County | Enter county |
| 8. | Mailing address (if different from home address.) | Enter mailing address |
| 9. | Apartment or suite number | Enter apartment or suite number |
| 10. | City | Enter city |
| 11. | State | Enter state |
| 12. | ZIP code | Enter ZIP code |
| 13. | County | Enter county |
| 14. | Phone number | Enter (___) ___-____ |
| 15. | Other (___) ___-____ number | Enter other (___) ___-____ number |
| 16. | Do you want to get information about this application by email? | Check Yes or No. If Yes, enter email address. |
| 17. | What is your preferred spoken or written language (if Not English) | Enter your preferred spoken or written language |
| 18. | Date of birth | Enter date of birth as month-month/day-day/year-year-year-year (mm/dd/yyyy) |
| 19. | Gender | Check Male or Female. |

20. Social security number (SSN) Enter ___ - ___ - _____.
21. Are you a U.S. citizen or U.S. national? Check Yes or No.
22. If you aren't a U.S. citizen or U.S. national, do you have eligible immigration status? Check Yes, and enter the following document type and ID number as appropriate.
- a. Immigration document type Enter type of immigration document
- b. Document ID number Enter document ID number
- c. Have you lived in the U.S. since 1996? Check Yes or No.
- d. Are you, or your spouse or parent a veteran or an active-duty member of the U.S. military? Check Yes or No.
- e. I am a citizen of the Federated States of Micronesia, the Republic of the Marshall Islands, or Palau. Check Yes or No.
23. Are you pregnant? Check Yes or No.
If Yes, how many babies are expected during this pregnancy? _____.
Expected due date _____.
24. Do you have a physical, mental or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc.) or live in a medical facility or nursing home? Check Yes or No.
- a. Do you have a disability? Check Yes or No.
25. If Hispanic/Latino, ethnicity (OPTIONAL - check all that apply.) Check all Hispanic/Latino, ethnicity as applicable. If your ethnicity is not listed, enter under Other as appropriate.
26. Race (OPTIONAL - check all that apply.) Check all race as applicable. If your race is not listed, enter under Other as appropriate.

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STEP 2 Current job & income information.

A responsible household member shall provide the information about current job and income:

- Employed Check if employed, start with question 1.
- Not Employed Check if not employed, skip to question 11.
- Self-Employed Check if self-employed, skip to question 10.

CURRENT JOB 1:

1. Employer name and address Enter employer name and address
2. Employer phone number Enter (____) ____ - _____
3. Average hours worked each WEEK Enter average hours worked.
4. Wages/tips (before taxes) Check when and provide amount paid.

CURRENT JOB 2:

- | | | |
|-----|---|---|
| 5. | Employer name and address | Enter employer name and address |
| 6. | Employer phone number | Enter (_ _ _) _ _ _ - _ _ _ _ |
| 7. | Average hours worked each WEEK | Enter average hours worked each week. |
| 8. | Wages/tips (before taxes) | Check when and enter amount paid. |
| 9. | In the past year, did you: | Check status of employment. |
| 10. | If self-employed, answer the following questions: | |
| | a. Type of work: | Enter type of work |
| | b. How much net income (profits once business expenses are paid) will you get from this self-employment this month? | Enter net income received. |
| 11. | OTHER INCOME THIS MONTH: | Check all that apply and enter amount and frequency. |
| 12. | Do you pay student loan interest (not the amount of the loan) that can be deducted on a federal income tax return? | Check Yes or No. If yes, enter amount and frequency. |
| 13. | YEARLY INCOME: | Complete only if your income changes from month to month. If you don't expect changes to your monthly income, skip to Step 3. |
| | Your total income this year | Enter your total income this year |
| | Your total income next year (if it will be different) | Enter your expected income for next year |

STEP 3 Your health coverage.

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|----|--|--|
| 1. | Are you enrolled in health coverage now from any of the following? | Check Yes or No. If Yes, check the type of coverage you have. If your health coverage is not listed, enter as Other and complete as appropriate. |
|----|--|--|

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STEP 4 Read & sign this application.

The person or the authorized representative who completed this application shall sign and date certifying that he/she:

- Is signing this application under penalty of perjury and know that he/she may be subject to penalties under state or federal law if false or untrue information is provided.
- Must report to Department of Human Services or the Hawaii Health Connector any changes or is different from what is written on the application.
- Knows that under federal law, discrimination isn't permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, or disability and he/she can file a complaint of discrimination under www.hhs.gov/ocr/office/file.
- Confirms that no one applying for health insurance on this application is incarcerated (detained or jailed). If not, list the name of person incarcerated.

Renewal of coverage in future years

The person or the authorized representative may identify the number of years his/her eligibility is to be renewed automatically.

If I'm eligible for Medicaid

The person or the authorized representative agrees to allow the Medicaid agency to pursue any payment from other health insurance, legal settlements, or other third parties and the right to pursue medical support from a spouse or parent; and as appropriate will be asked to cooperate with the agency that collects medical support from an absent parent. If cooperating with medical support will harm him/herself or their children, he/she will tell Medicaid and may not have to cooperate.

My right to appeal

If the person or the authorized representative thinks the Department of Human Services or the Hawaii Health Connector made a mistake, he/she:

- Can appeal its decision and find out how to appeal by contacting someone at **1-877-628-5076**.
- Can be represented in the process by someone other than him/herself.
- Will have their eligibility and other important information explained to him/her.

Sign this application.

The person or authorized representative who filled out Step 1 should sign this application. If the person signing is the authorized representative, he/she may sign on the signature line as long as they have provided the information required in Appendix C.

Signature

Enter signature.

Date

Enter (mm/dd/yyyy)

STEP 5 Mail your signed application to:

Completed applications can be mailed, dropped off or faxed to the Health Insurance Marketplace or the Med-QUEST Eligibility office as listed.

Information is also provided as to how to register to vote.

APPENDIX A

Health Coverage from Jobs

Completion of Appendix A is only required for an adult who is eligible for health coverage from a job. A copy of Appendix A must be attached for each job that offers coverage.

Tell us about the job that offers coverage.

The Employer Coverage Tool must be taken to the employer who offers coverage to help complete the questions. Appendix A only needs to be submitted with the application that is sent in.

EMPLOYEE Information

- | | | |
|----|-------------------------------------|--|
| 1. | Employee name (First, Middle, Last) | Enter employee's first, middle, and last name. |
| 2. | Employee Social Security number | Enter ___ - ___ - ____. |

EMPLOYER Information

- | | | |
|-----|---|---|
| 3. | Employer name | Enter employer name |
| 4. | Employer Identification Number (EIN) | Enter EIN |
| 5. | Employer address | Enter employer address |
| 6. | Employer phone number | Enter (___) ___ - ____ |
| 7. | City | Enter city |
| 8. | State | Enter state |
| 9. | ZIP Code | Enter ZIP code |
| 10. | Who can we contact about employee health coverage at this job? | Enter name of employer health coverage contact person. |
| 11. | Phone number (if different from above) | Enter (___) ___ - ____ |
| 12. | Email address | Enter email address |
| 13. | Are you currently eligible for coverage offered by this employer, or will you become eligible in the next 3 months? | Check Yes or No. If Yes, complete question 13a and list the names of anyone else who is eligible for coverage from this job. If No, go to Step 5 in the application |
| | 13a. If you're in a waiting or probationary period, when can you enroll in coverage? | Enter (mm/dd/yyyy). |

Tell us about the health plan offered by this employer.

- | | | |
|-----|--|------------------|
| 14. | Does the employer offer a health plan that meets the minimum value standard*? | Check Yes or 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? Enter amount of premium.
- b. How often? Enter frequency of premium paid.
Date of change Enter (mm/dd/yyyy)
- 16. What change will the employer make for the new plan year (if known)? Check if employer will offer health coverage or not. If employer will start offering health coverage, 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. (See question 15.)
Enter amount to be paid in premium.
- a. How much would the employee have to pay in premiums for that plan?
- b. How often? Check frequency of premium paid.
Date of change Enter (mm/dd/yyyy).

* An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs 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).

EMPLOYER COVERAGE TOOL

Completion of the Employer Coverage Tool will help answer questions in Appendix A about any employer health coverage that the individual is eligible for (even if it's from other person's job, like a parent or spouse). The information in the numbered boxes matches the boxes on Appendix A. One tool must be completed for each employer that offers health coverage.

EMPLOYEE Information

The employee needs fill out this section.

- 1. Employee name (First, Middle, Last) Enter first, middle and last name.
- 2. Employee Social Security number Enter ___ - __ - ____

EMPLOYER Information

Ask the employer for this information.

- 3. Employer Name Enter employer name.
- 4. Employer Identification Number (EIN) Enter EIN
- 5. Employer address Enter employer address
- 6. Employer phone number Enter (___) ___ - ____
- 7. City Enter city
- 8. State Enter state
- 9. ZIP Code Enter ZIP code
- 10. Who can we contact about employee health coverage at this job? Enter name of employer health coverage contact person.
- 11. Phone number (if different from above) Enter (___) ___ - ____
- 12. Email address Enter email address
- 13. Are you currently eligible for coverage offered by this employer, or will you become eligible in the next 3 months? Check Yes or No. If Yes, complete question 13a. If No, stop and return this form to employee..
- 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? Enter (mm/dd/yyyy)

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 Check Yes or No. If Yes, check spouse or dependents. If No, go to question 14.
- 14. Does the employer offer a health plan that meets the minimum value standard*? Check Yes or No. If Yes, go to question 15. If 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? Enter amount of premium.

b. How often? Check frequency of premium.

If the plan year will end soon and you know that 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? Check if employer will or won't offer health coverage. If offered, 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? Enter amount paid in premium.

b. How often? Check frequency of premium.

Date of change Enter (mm/dd/yyyy)

* An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs 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).

APPENDIX B

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

Completion of Appendix B is only required if the individual or a family member are American Indian or Alaska Native. Appendix B must be submitted with the 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 programs, 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

- | | | |
|----|--|--|
| 1. | Name (First, Middle, Last) | Enter first, middle, and last name |
| 2. | Member of a federally recognized tribe? | Check Yes or No. If Yes, enter name of tribe |
| 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?
If No, is this person is eligible to get services from the Indian Health Service, a tribal Health program, or urban Indian health Program, or through a referral from one of these programs? | Check Yes or No.

Check Yes or 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: <ul style="list-style-type: none">• 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 | Enter amount and frequency money received. |

AI/AN PERSON 2

Refer to instructions under AI/AN PERSON 1.

APPENDIX C

Assistance with Completing this Application

You can choose an authorized representative.

- | | | |
|----|--|------------------------------------|
| 1. | Name of authorized representative (First name, Middle name, Last name) | Enter first, middle, and last name |
| 2. | Address | Enter address |
| 3. | Apartment or suite number | Enter apartment or suite number |
| 4. | City | Enter city |
| 5. | State | Enter State |
| 6. | ZIP code | Enter ZIP code |
| 7. | Phone number | Enter (_ _) _ _ - _ _ _ _ |
| 8. | Organization name | Enter organization name |
| 9. | ID number (if applicable) | Enter ID number |

An individual who is signing below is authorizing someone to sign their application, get official information about this application, and act on their behalf on all future matters with this agency.

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

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

- | | | |
|----|---|---|
| 1. | Application start date | Enter (mm/dd/yyyy) |
| 2. | First name, Middle name, Last name & Suffix | Enter first, middle, last name & suffix |
| 3. | Organization name | Enter organization name |
| 4. | ID number (if applicable) | Enter ID number |