State of Hawaii
Department of Human Services

Application for Health Coverage & Help Paying Costs (Short Form)

THINGS TO KNOW

Use this application to see what coverage 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?

Single adults who:

- Aren't offered health coverage from their employer
- Don't have any dependents and can't be claimed as a dependent on someone else's tax return

NOTE: If any of the following apply, you need to fill out a different form to make sure you get the most benefits possible:

- You're married or have dependent children.
- You were in the foster care system, and you're under age 26.
- You have items that can be deducted from your income. If your only deduction is student loan interest, you **can** use this form.
- You're American Indian or Alaska Native.
- You have special circumstances that require additional services and/or benefits.

Apply faster online

- Apply faster online at mybenefits.hawaii.gov.

What you may need to apply

- Your Social Security number (or document number if you're a legal immigrant)
- Employer and income information (for example, from paystubs, W-2 forms, or wage and tax statements)

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 3. **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. Filling out this application doesn't mean you have to buy health coverage.

Get help with this application

- **Online:** mybenefits.hawaii.gov.
- **Phone:** Call our Help Center at **1-877-628-5076.**
- **In person:** There may be counselors in your area who can help. Visit mybenefits.hawaii.gov, or call **1-877-628-5076** for more information.

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 **1-855-585-8604**.

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，您的通話將被擱置直到接通翻譯服務。其他人類服務部門的服務, 您可以致電到 1- 888 - 764-7586.	**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 umawayg iti 1-888-764-7586 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 １－８８８－７６４－７５８６ 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 1-888 - 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 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 1-888-764-7586 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 serbisio 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 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 1-888-764-7586 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**. **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 **1-855-585-8604**.

STEP 1 Tell us about yourself.

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 or written language (if not English)?

18. Date of birth (mm/dd/yyyy)

19. Gender ☐ Male ☐ Female

20. Social Security number (SSN) ___ ___ ___ - ___ ___ - ___ ___ ___ ___

We need this if you want health coverage and have an SSN. We use SSNs to check income and other information to see if you're eligible for help with health coverage costs. If you need help getting an SSN, call 1-800-772-1213 or visit **socialsecurity.gov**. TTY users should call 1-800-325-0778.

21. Are you a U.S. citizen or U.S. national? ☐ Yes ☐ No

22. **If you aren't a U.S. citizen or U.S. national,** do you have eligible immigration status?

☐ Yes. Fill in your document type and ID number below.

a. Immigration document type _____

b. Document ID number _____

c. Have you lived in the U.S. since 1996? ☐ Yes ☐ No

d. Are you a veteran or an active-duty member of the U.S. military? ☐ Yes ☐ No

e. I am a citizen of the Federated States of Micronesia, the Republic of the Marshall Islands, and Palau. ☐ Yes ☐ No

23. Are you pregnant? ☐ Yes ☐ 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? ☐ Yes ☐ No

a. Do you have a disability? ☐ Yes ☐ No

25. **If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply.)**

☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other _____

26. **Race (OPTIONAL—check all that apply.)**

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

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STEP 2 Current job & income information

☐ **Employed –** If you're currently employed, tell us about your income. Start with question 1.

☐ **Not Employed –** Skip to question 11. ☐ **Self Employed –** Skip to question 10.

CURRENT JOB 1:

1. Employer name and address	2. Employer phone number	3. Average hours worked each week
	( ) –	

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

$ _____

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

5. Employer name and address	6. Employer phone number	7. Average hours worked each week
	( ) –	

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

$ _____

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

10. **If self-employed, answer the following questions:**

a. Type of work

_____

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

$ _____

11. **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, veteran's payment, or Supplemental Security Income (SSI).

☐ None

☐ Unemployment **$** _____ How often? _____

☐ Pensions **$** _____ How often? _____

☐ Social Security **$** _____ How often? _____

☐ Retirement accounts **$** _____ How often? _____

☐ Alimony received **$** _____ How often? _____

☐ Net farming/fishing **$** _____ How often? _____

☐ Other income **$** _____ How often? _____

Type: _____

12. Do you pay student loan interest (not the amount of the loan) that can be deducted on a federal income tax return?

☐ **YES. If yes,** how much **$** _____ How often? _____ ☐ **NO.**

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

STEP 3 Your health coverage

1. **Are you enrolled in health coverage now from any of the following?**

☐ **YES. If yes,** check which coverage you have. ☐ **NO.**

☐ Medicaid

☐ CHIP

☐ Medicare

☐ TRICARE (don't check if you have Direct Care or Line of Duty)

☐ Peace Corps

☐ VA health care programs

☐ Other

Name of health insurance

_____

Policy number

_____

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STEP 4 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 state or federal law if I intentionally provide false or untrue information.
- I know that 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 **1-877-628-5076** to report any changes. I understand that a change in my information could affect my eligibility.
- 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 confirm that I'm not incarcerated (detained or jailed).
- I confirm that next year I expect to file a federal income tax return, won't claim dependents on that return, and can't be claimed as a dependent on anyone else's federal income tax return.
- I confirm that I'm not offered health coverage from an employer.

We need this information to check your eligibility for help paying for health coverage if you choose to apply. We'll check your answers using information in our electronic databases and databases from the Internal Revenue Service (IRS), Social Security, the Department of Homeland Security, and/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 Department of Human Services and the Hawaii Health Connector to use income data, including information from tax returns. The Department of Human Services or 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 year ☐ Don't use information from tax returns to renew my coverage.

If I'm eligible for Medicaid

If I enroll in Medicaid, I'm giving the Medicaid agency my rights to pursue and get any money from other health insurance, legal settlements, or other third parties.

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 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 as long as you have provided the information required in Appendix C.

Signature	Date (mm/dd/yyyy)

STEP 5 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
88 Kanoelehua Ave.
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 737
Lanai City, HI 96763-0737

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 a voter registration form at **hawaii.gov/elections**.

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 0938-1191. 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 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.

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 **1-855-585-8604**.

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

1. Employee name (First, Middle, Last)	2. Employee Social Security number ___ ___ ___ - ___ ___ - ___ ___ ___ ___

EMPLOYER Information

3. Employer name		4. Employer Identification Number (EIN) ___ ___ - ___ ___ ___ ___ ___ ___ ___
5. Employer 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 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 here 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 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.* (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 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)

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 **1-855-585-8604**.

EMPLOYER COVERAGE TOOL

Form Approved
OMB No. 0938-1191

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 information.

3. Employer name	4. Employer Identification Number (EIN) ___ ___ - ___ ___ ___ ___ ___ ___ ___
5. Employer address (notices 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. Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 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 didn't 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 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?

☐ 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 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)

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APPENDIX B

Form Approved
OMB No. 0938-1191

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 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	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 _____ ☐ No	☐ Yes If yes, tribe name _____ ☐ 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 Service, 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 Service, 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?_____

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 **1-855-585-8604**.

APPENDIX C

Form Approved
OMB No. 0938-1191

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)

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 somebody 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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