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 However, if you do not have online access and would like a copy or need it in a larger font, you may contact customer service at 1-800-316-8005 (TTY: 711 or 1-800-603-1201) or pick one up at any of our MQD offices across the state.

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 1-800-316-8005 (TTY: 711 or 1-800-603-1201). 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 Customer Service at 1-800-316-8005 (TTY: 711 or 1-800-603-1201) 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 1-800-316-8005 (TTY: 711 or 1-800-603-1201) for more information.

NEED HELP WITH YOUR APPLICATION? Visit mybenefits.hawaii.gov or call us at 1-800-316-8005. If you need help in a language other than English, call 1-800-316-8005 and tell the customer service representative the language you need. We will get you help at no cost to you. TTY users should call 711 or 1-800-603-1201.

Do you need help in another language? We will get you a free interpreter. Call **1-800-316-8005** to tell us which language you speak. (TTY: 711 or 1-800-603-1201).	**English** 
您需要其它語言嗎？如有需要，請致電 **1-800-316-8005**，我們會提供免費翻譯服務 (TTY: 711 或 1-800-603-1201).	**Cantonese** 
En mi niit alilis lon pwal eu kapas? Sipwe angei emon chon chiaku ngonuk ese kamo. Kokori **1-800-316-8005** omw kopwe ureni kich meni kapas ka ani. (TTY: 711 ika 1-800-603-1201).	**Chuukese** 
Avez-vous besoin d'aide dans une autre langue? Nous pouvons vous fournir gratuitement des services d'un interprète. Appelez le **1-800-316-8005** pour nous indiquer quelle langue vous parlez. (TTY: 711 ou 1-800-603-1201).	**French** 
Brauchen Sie Hilfe in einer andereren Sprache? Wir koennen Ihnen gern einen kostenlosen Dolmetscher besorgen. Bitte rufen Sie uns an unter **1-800-316-8005** und sagen Sie uns Bescheid, welche Sprache Sie sprechen. (TTY: 711 oder 1-800-603-1201).	**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 **1-800-316-8005** `oe ia la kaua a e ha`ina `oe ia la maua mea `olelo o na `aina `e. (TTY: 711 a 1-800-603-1201).	**Hawaiian** 
Masapulyo kadi ti tulong iti sabali a pagsasao? Ikkandakayo iti libre nga paraipatarus. Awaganyo ti **1-800-316-8005** tapno ibagayo kadakami no ania ti pagsasao nga ar-aramatenyo. (TTY: 711 wenno 1-800-603-1201).	**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、**1-800-316-8005** 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: 711 または 1-800-603-1201).	**Japanese** 
다른언어로 도움이 필요하십니까? 저희가 무료로 통역을 제공합니다. **1-800-316-8005** 로 전화해서 사용하는 언어를 알려주십시요 (TTY: 711 또는 1-800-603-1201).	**Korean** 
您需要其它语言吗？如有需要, 请致电 **1-800-316-8005**，我们会提供免费翻译服务 (TTY: 711 或 1-800-603-1201).	**Mandarin** 
Kwoj aikuij ke jiban kin juon bar kajin? Kim naj lewaj juon am dri ukok eo ejjelok wonen. Kirtok **1-800-316-8005** im kwalok non kim kajin ta eo kwo melele im kenono kake. (TTY: 711 ak 1-800-603-1201).	**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 **1-800-316-8005** pea e mana'o mia se fesosoani mo se faaliliu upu. (TTY: 711 po o le1-800-603-1201).	**Samoan** 
¿Necesita ayuda en otro idioma? Nosotros le ayudaremos a conseguir un intérprete gratuito. Llame al **1-800-316-8005** y diganos que idioma habla. (TTY: 711 o 1-800-603-1201).	**Spanish** 
Kailangan ba ninyo ng tulong sa ibang lengguwahe? Ikukuha namin kayo ng libreng tagasalin. Tumawag sa **1-800-316-8005** para sabihin kung anong lengguwahe ang nais ninyong gamitin. (TTY: 711 o 1-800-603-1201).	**Tagalog** 
'Oku ke fiema'u tokoni 'iha lea makehe? Te mau malava 'o 'oatu ha fakatonulea ta'etotongi. Telefoni ki he **1-800-316-8005** 'o fakaha mai pe koe ha 'ae lea fakafonua 'oku ke ngaue'aki. (TTY: 711 pe 1-800-603-1201).	**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 **1-800-316-8005** nói cho chúng tôi biết bạn dùng ngôn ngữ nào. (TTY: 711 hoặc 1-800-603-1201).	**Vietnamese** Việt Nam
Gakinahanglan ka ba ug tabang sa imong pinulongan? Amo kang mahatagan ug libre nga maghuhubad. Tawag sa **1-800-316-8005** aron magpahibalo kung unsa ang imong sinulti-han. (TTY: 711 o 1-800-603-1201).	**Visayan (Cebuano)** 

NEED HELP WITH YOUR APPLICATION? Visit mybenefits.hawaii.gov or call us at 1-800-316-8005. If you need help in a language other than English, call 1-800-316-8005 and tell the customer service representative the language you need. We will get you help at no cost to you. TTY users should call 711 or 1-800-603-1201.

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. Are you a resident or intend to be a resident of Hawaii? ☐ **Yes** ☐ **No**

3. Home address (If Homeless, please write "Homeless" here with appropriate city, state and zip code and mark this box ☐)			4. Apartment or suite number
5. City	6. State	7. ZIP code	8. County
9. Mailing address (if different from home address)			10. Apartment or suite number
11. City	12. State	13. ZIP code	14. County

15. Home phone number	16. Work phone number	17. Other phone number

18a. What is your preferred method of contact? ☐ **Mail** ☐ **Phone** ☐ **Email**

18b. Would you like to receive notices regarding your application by email? ☐ **Yes**, Email Address:_____ ☐ **No**

If Yes, please provide your email address and complete Question 9 on this page. Your request to receive electronic notices cannot be processed if you do not have a mailing address.

19. What is your preferred spoken language (if not English)?	20. What is your preferred written language (if not English)?
21. How many family members live with you?	22. 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. 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

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

STEP 2: PERSON 1 Start With Yourself

Complete Step 2: PERSON 1 for yourself.

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 a SSN. Providing your SSN can be helpful if you do not want health coverage 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 tax dependents on your tax return? ☐ **Yes** ☐ **No**
If yes, write name(s) of dependents: _____
c. Will you be claimed as a tax 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 the 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, including Kinship and State Adoption assistance and receiving Medicaid in Hawaii when you turned 18 or older?
☐ **Yes** ☐ **No**

16. Are you a full-time student? ☐ **Yes** ☐ **No** If Yes, When is your expected graduation date? _____

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:

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

STEP 2: PERSON 1 (Continue With Yourself)

Job & Income Information

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

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

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

JOB 1:

☐ Changed jobs ☐ Stopped working ☐ Started working fewer hours ☐ None of these

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:

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

☐ Changed jobs ☐ Stopped working ☐ Started working fewer hours ☐ None of these

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. If self-employed, answer the following questions:

a. Type of work:_____

b. How much net income (gross income minus allowable expenses) will you get this month from self-employment?

$_____

28. **OTHER INCOME THIS MONTH:** Check all that apply, the amount, and how often received.
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? _____
☐ Educational Grant/Work Study $_____
☐ Other Type of income _____ $ _____ How often? _____

29. **DEDUCTIONS:** Check all the deductions that were filed on your federal income tax return.
NOTE: You should not include a cost that you already considered in your answer to net self-employment (question 27b)

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

30. **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) $

If there are more people to include, please make a copy of pages 4 and 5.
Complete and attach additional pages to this application.
If this is not applicable skip to page 6 of 9.

NEED HELP WITH YOUR APPLICATION? Visit mybenefits.hawaii.gov or call us at 1-800-316-8005. If you need help in a language other than English, call 1-800-316-8005 and tell the customer service representative the language you need. We will get you help at no cost to you. TTY users should call 711 or 1-800-603-1201.

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

STEP 2: PERSON 2

Complete Step 2 PERSON 2 for your spouse/partner and/or 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, complete Step 2 PERSON 2 for anyone in your household /family (refer to Page 1 of 9, Step 2)

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 a SSN. Providing your SSN can be helpful if you do not want health coverage 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**
8. Are you a resident or intend to be a resident of Hawaii? ☐ **Yes** ☐ **No**
9. **If no**, Home address (If Homeless, please enter "Homeless" here with appropriate city, state and zip code and mark this box ☐)
10. 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 tax dependents on his/her tax return? ☐ **Yes** ☐ **No**
If yes, write name(s) of dependents: _____
c. Will PERSON 2 be claimed as a tax 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? _____
11. Is PERSON 2 pregnant? ☐ **Yes** ☐ **No If yes,** how many babies are expected during this pregnancy? _____ Expected Due Date: _____
12. 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.
13. 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**
14. 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**
15. Is PERSON 2 a U.S. citizen or U.S. national? ☐ **Yes. If yes,** skip to Question 18. ☐ **No**
16. 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)

17. Provide the date of entry to the U. S. found on your immigration document listed in question 16. (mm/dd/yyyy) _____
a. Is PERSON 2 a citizen of the ☐ Federated States of Micronesia, ☐ Republic of the 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**
18. Were you in Foster Care, including Kinship and State Adoption assistance and receiving Medicaid in Hawaii when you turned 18 or older?
☐ **Yes** ☐ **No**
19. Is PERSON 2 a full-time student? ☐ **Yes** ☐ **No** If Yes, When is your expected graduation date? _____
20. If Hispanic/Latino, ethnicity (**OPTIONAL**: mark all that apply.)
☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other _____
21. 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. ➡

? **NEED HELP WITH YOUR APPLICATION? Visit mybenefits.hawaii.gov or call us at 1-800-316-8005. If you need help in a language other than English, call 1-800-316-8005 and tell the customer service representative the language you need. We will get you help at no cost to you. TTY users should call 711 or 1-800-603-1201.**

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

STEP 2: PERSON 2

Current Job & Income Information

☐ **Employed**
If PERSON 2 is currently employed, tell us about his/her income. Start with question 22.

☐ **Self-employed**
Skip to question 30.

☐ **Not employed**
Skip to question 31.

JOB 1:

☐ Changed jobs ☐ Stopped working ☐ Started working fewer hours ☐ None of these

Start Date: **End Date:**

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:

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

☐ Changed jobs ☐ Stopped working ☐ Started working fewer hours ☐ None of these

Start Date: **End Date:**

26. Employer name and address:

27. Employer phone number:

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

$_____

29. Average hours worked each WEEK:

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

a. Type of work:_____

b. How much net income (gross income minus allowable expenses) will you get this month from self-employment?

$_____

31. **OTHER INCOME THIS MONTH:** Check all that apply, the amount and how often PERSON 2 receives 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? _____
☐ Educational Grant/Work Study $_____
☐ Other type of income _____ $ _____ How often? _____

32. **DEDUCTIONS:** Check all the deductions that were filed on PERSON 2 federal income tax return.
NOTE: You should not include a cost that you already considered in your answer to net self-employment (question 30b.)

☐ Alimony paid $_____ How often? _____
☐ Student loan interest $_____ How often? _____
☐ Other type of deductions _____ How often? _____ $ _____

33. **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) $

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 and continue to STEP 3

NEED HELP WITH YOUR APPLICATION? Visit mybenefits.hawaii.gov or call us at 1-800-316-8005. If you need help in a language other than English, call 1-800-316-8005 and tell the customer service representative the language you need. We will get you help at no cost to you. TTY users should call 711 or 1-800-603-1201.

Please print using black or dark ink only.

Mark each box [☐] as appropriate, with an "X", like this → ☒.

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 or Domestic Partnership
- Niece/Nephew (including step)
- Foster Child
- Other Related (i.e. in law living in home)

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 six (6) people in your family, you will need to make a copy of this page and continue with Person 7 and attach to this application.

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

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,** also complete 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 **Family Health Coverage PERSON 1**
- ☐ **No If no**, SKIP to Step 6.

Family Health Coverage PERSON 1

Name of person 1 enrolled in health coverage:	
Type of Coverage(s): ☐ Employer Insurance ☐ COBRA ☐ 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
Where you ever in an accident? ☐ **Yes** ☐ **No** **If Yes, are you still incurring medical expenses because of it?** ☐ **Yes** ☐ **No**	
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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Please print using black or dark ink only.
Mark each box [☐] as appropriate, with an "X", like this → ☒.

Family Health Coverage PERSON 2

Name of person 2 enrolled in health coverage:

Type of Coverage(s): ☐ Employer Insurance ☐ COBRA ☐ 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

Where you ever in an accident? ☐ **Yes** ☐ **No** **If Yes, are you still incurring medical expenses because of it?** ☐ **Yes** ☐ **No**

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 ☐ 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

Where you ever in an accident? ☐ **Yes** ☐ **No** **If Yes, are you still incurring medical expenses because of it?** ☐ **Yes** ☐ **No**

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 ☐ 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

Where you ever in an accident? ☐ **Yes** ☐ **No** **If Yes, are you still incurring medical expenses because of it?** ☐ **Yes** ☐ **No**

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 ☐ 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

Where you ever in an accident? ☐ **Yes** ☐ **No** **If Yes, are you still incurring medical expenses because of it?** ☐ **Yes** ☐ **No**

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 ☐ 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

Where you ever in an accident? ☐ **Yes** ☐ **No** **If Yes, are you still incurring medical expenses because of it?** ☐ **Yes** ☐ **No**

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?

If you have more than (6) six people who have health coverage now, make a copy of this page and continue with *PERSON 7* in the Family Health Coverage PERSON 2 section of this page.

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

!!!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 **1-800-316-8005** (**TTY: 711 or 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 household's information could affect the eligibility for member(s) of my household.
- The Department of Human Services (DHS) complies with applicable Federal and State civil rights laws and does not discriminate, exclude or treat people differently on the basis of race, color, national origin, age, disability, or sex/gender (expression or identity) or any protected class under federal or state laws.
- DHS is able to provide aids and services (at no cost to the individual) to people with disabilities, such as: qualified sign language, and written information in other formats. (large print, audio, accessible electronic formats) and language services (at no cost to the individual) to people whose primary language is not English, such as: qualified interpreters and information written in languages other than English.
- If I believe that DHS or its service providers have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, I can file a discrimination complaint with: **Civil Rights Compliance Officer by e-mail at DHSCivilRightsBox@dhs.hawaii.gov or call (808) 586-4955 or 711 Hawaii Relay Service, fax (808) 586-4990 or write to: Civil Rights Compliance Officer, P. O. Box 339, Honolulu, HI 96809-0339. DHS discrimination complaint forms are available at https://humanservices.hawaii.gov in the Civil Rights Corner under Forms.**
- I can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at ***https://ocrportal.hhs.gov/ocr/portal/lobby.jsf,*** or by mail or phone at: U.S. **Department of Health and Human Services, Office for Civil Rights (OCR), 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, Phone: 1(800) 368–1019, TDD: 1(800) 537–7697**.
- 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.

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 **1-800-316-8005** (TTY: 711 or 1-800-603-1201). 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 must sign this application. If you are an Authorized Representative, sign here and you must complete Appendix C.

Signature	Date (mm/dd/yyyy)

STEP 7 Mail Your Signed Application To:

MQD-Oahu Section
P.O. Box 3490
Honolulu, HI 96811-3490

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

MQD-Kauai Section
4473 Pahee Street, Suite A
Lihue, HI 96766-2037

MQD-East Hawaii Section
1404 Kilauea Avenue
Hilo, HI 96720-4670

MQD-Lanai Unit
P.O. Box 1619
Kaunakakai, HI 96748-1619

MQD-Maui Section
Millyard Plaza
210 Imi Kala Street, Suite 101
Wailuku, HI 96793-1274

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

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

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

NEED HELP WITH YOUR APPLICATION? Visit mybenefits.hawaii.gov or call us at 1-800-316-8005. If you need help in a language other than English, call 1-800-316-8005 and tell the customer service representative the language you need. We will get you help at no cost to you. TTY users should call 711 or 1-800-603-1201.

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 1-800-316-8005. 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 1-800-316-8005. If you need help in a language other than English, call 1-800-316-8005 and tell the customer service representative the language you need. We will get you help at no cost to you. TTY users should call 711 or 1-800-603-1201.

STATE OF HAWAII
NATIONAL VOTER REGISTRATION ACT QUESTIONNAIRE

You may register to vote in Hawaii if:

1. You are a United States citizen.
2. You are a resident of the State of Hawaii.
3. You are at least 16 years of age and understand that you must be 18 years of age by election day to vote.
4. You are not an incarcerated felon.
5. You are not registered in any other state, unless you cancel that registration. (There is an area on the Hawaii registration application for you to cancel if needed.)

If you are not registered to vote where you live now, would you like to apply to register to vote here today? (Check one.)

☐ YES ☐ NO

If you do not check either box, you will be considered to have decided not to register to vote at this time.

Important Notices

Applying to register or declining to register to vote will not affect the amount of assistance that you will be provided by this agency.

If you would like help filling out the voter registration form, we will help you in person or you can call: **1-800-316-8005 (TTY: 711 or 1-800-603-1201)**. The decision to seek or accept help is yours. You may fill out the application form in private.

Applying to register or declining to register to vote will remain confidential and will be used only for your voter registration purposes.

If you need additional information about voting or if you believe that someone has interfered with your right to register or not to register to vote; or your right to privacy in deciding whether or not to register or applying to register to vote, you may contact:

Office of Elections
802 Lehua Avenue
Pearl City, Hawaii 96782
Phone: (808) 453-VOTE
(8683)
Neighbor Islands Toll Free: 1-800-442-VOTE (8683)

_____
Name

_____ _____
Signature Date

State Agency I.D. # A 0 1 7

FIRST TIME VOTERS MAILING THIS APPLICATION

If you are 1) registering to vote for the first time in the State of Hawaii; 2) mailing this application; and 3) do not have a HI Driver License, HI State ID, or last 4-digits of a Social Security Number, you are required to provide proof of identification.

Proof of identification includes a copy of:

- A current and valid photo identification; or
- A current utility bill, bank statement, government check, paycheck, or other government document that shows your name and address.

SUBMITTING APPLICATION

Mail or deliver your application to your Clerk's Office at the address below.

County of Hawaii
25 Aupuni St., Rm. 1502
Hilo, HI 96720

County of Kauai
4386 Rice St., Rm. 101
Lihue, HI 96766

County of Maui
200 S. High St., Rm. 708
Wailuku, HI 96793

City & County of Honolulu
530 S. King St., Rm. 100
Honolulu, HI 96813

DEADLINE TO SUBMIT APPLICATION

Registering to Vote: No later than 30 days prior to the election.

Requesting a Permanent Absentee Ballot: No later than 7 days prior to the election.

LANGUAGE ASSISTANCE

若想獲得電子檔的翻譯材料，或者需要協助填表事宜，請聯繫 選舉辦公室 (Office of Elections).

Para kadagiti naipatarus a materiales a mainaig iti eleksion wenno tulong iti lengguahe tapno makompletoyo daytoy nga aplikasion, awagan ti Opisina Dagiti Eleksion (Office of Elections).

CONTACT US

For voter registration and absentee voting information, contact your **Clerk's Office**.

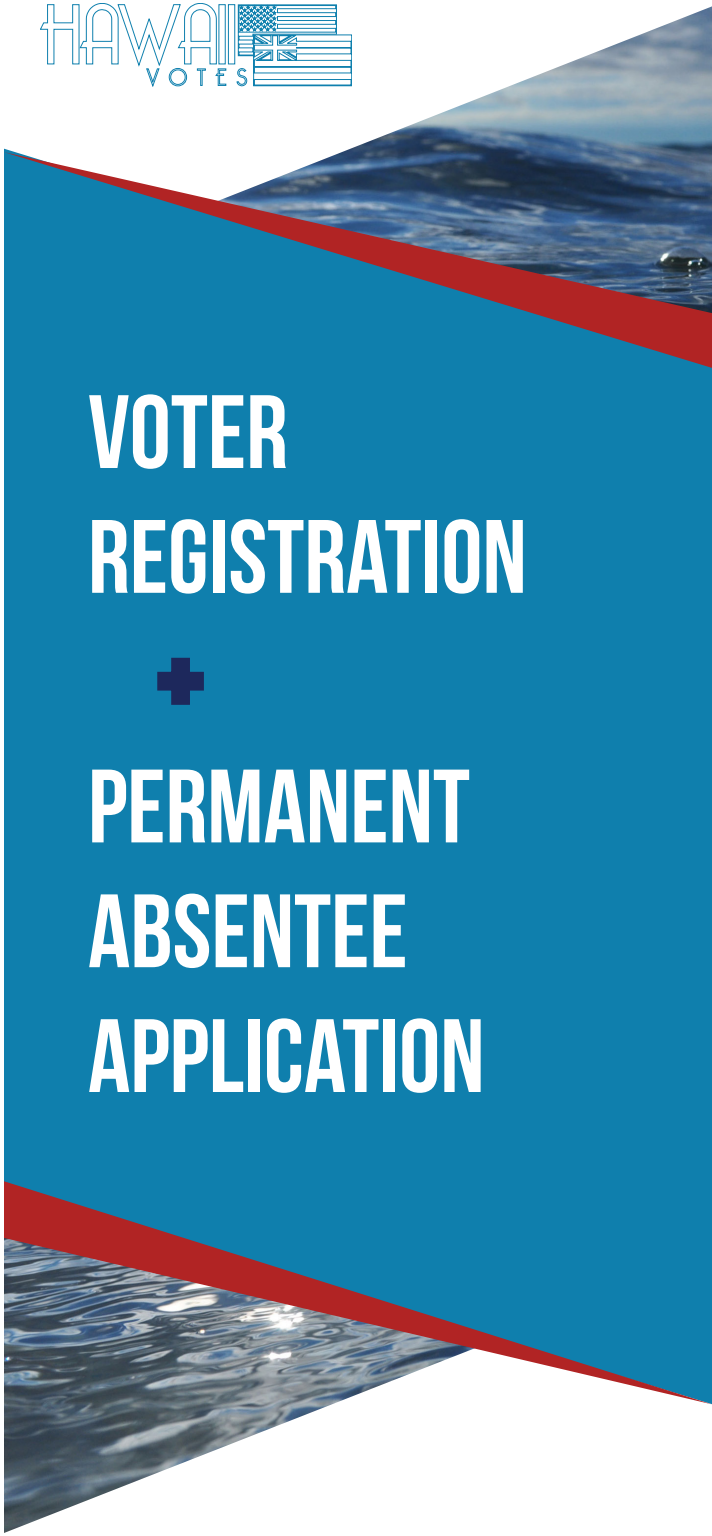
County of Hawaii .....(808) 961-8277
County of Maui.....(808) 270-7749
County of Kauai .....(808) 241-4800
City & County of Honolulu.....(808) 768-3800

For additional voting information, contact the **Office of Elections**.

(808) 453-VOTE (8683)
Toll Free: 1-800-442-VOTE (8683)
TTY: (808) 453-6150
Toll Free TTY: 1-800-345-5915

Email: elections@hawaii.gov
Website: www.elections.hawaii.gov

HAWAII VOTES



VOTER REGISTRATION + PERMANENT ABSENTEE APPLICATION

Hawaii Voter Registration & Permanent Absentee Application

This application can be used for:
- First time registration
- Request to vote by mail permanently
- Name change
- Address change

Please print clearly in black ink.

1

Are you a citizen of the United States of America? ☐ **Yes** ☐ **No**

Are you at least 16 years of age? (Must be 18 to vote) ☐ **Yes** ☐ **No**

Are you a resident of the State of Hawaii?[1] ☐ **Yes** ☐ **No**

If you answered "No" to any of the above, DO NOT complete this form.

[1]**The residence stated in this affidavit is not simply because of my presence in the State, but was acquired with the intent to make Hawaii my legal residence with all the accompanying obligations therein.**

2

Last Name | First Name | M.I. | Suffix (Jr., II)

3

HI Driver License or HI State ID Number

If you do not have either, complete box 3b.

3b

☐ I do not have a HI Driver License or HI State ID.
Provide the last 4-digits of your Social Security Number. ___ ___ ___ ___

☐ I do not have a HI Driver License, HI State ID, or SSN.

4

Date of Birth | Phone Number | Email

5

Residence Address (P.O. Box, R.R., S.R. are not acceptable) | Apt. Number | City | Zip Code

Mailing Address in Hawaii ☐ Same as Residence Address | Apt. Number | City | Zip Code

If your residence does not have a street address, describe the location (cross streets, landmarks).

6

Are you registered to vote in another state?

☐ **Yes.** I hereby authorize cancellation of my previous registration.
Complete box 6b.

6b

Last Registered Address, County, State, and Zip Code

7

Would you like to permanently receive absentee ballots by mail?

☐ **Yes.** I request to permanently receive absentee ballots at the mailing address associated with my voter registration.

I understand that my permanent absentee voter status will be terminated if: 1) I request termination in writing; 2) I die, lose voting rights, register in another jurisdiction, or am otherwise disqualified from voting; 3) my absentee ballot, voter notification postcard, or any other election mail is returned to the clerk as undeliverable for any reason; or 4) I do not return my ballot by 6:00 PM on election day in both the primary and general election of an election year. If so, I understand that I must reapply for permanent absentee status.

8

Warning: Any person who knowingly furnishes false information may be guilty of a Class C felony.
I hereby swear (or affirm) that all information furnished on this application is true and correct.

SIGN HERE | Date

If you are unable to sign, mark the signature line and have a witness provide signature, address, and phone number.

Office Use Only

ID Number: A017 | Location Code | Document Number

Notice: The identity of the voter registration agency through which any particular voter was registered shall not be publicly disclosed. A person's declination to register to vote is also confidential and is used for voter registration purposes only (National Voter Registration Act of 1993).