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 10. **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 le 1-800-603-1201).	**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)**

Rev. 08/2019

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

STEP 1 Tell Us About Yourself.

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

1. First name	Middle name	Last name	Suffix

2. Home address - *If Homeless, please write "Homeless" here with appropriate city, state and zip code and mark this box* ☐			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. Home phone number	15. Cell phone number	16. Other phone number
( ) –	( ) –	( ) –

17. Email Address Note: Your email and phone number will make it quicker for us to contact you if more information is needed.

18. What is your preferred method of contact? Please select all that apply. ☐ Mail ☐ Phone ☐ Email

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? Detailed questions are in Step 3 of this application.

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

☐ Yes ☐ No Name: _____ Start Date: _____ End Date: _____

CLEAR FORM

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.

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 5 and 6 for each additional person and attach the pages to this application. As a condition of eligibility, a Social Security number must be provided for each individual (including Children over the age of 1) who is applying for Medicaid or an application filed for SSN before applying for assistance*.

However, if you are a parent or spouse who is not applying for medical help for yourself, we may still need your income to determine eligibility for the household members who are applying. If you choose not to provide an SSN, we will need to follow up with you to get information about the non-applicant's income. Your SSN will help us to process eligibility faster during application and renewals.

*If someone wants help getting an SSN, call 1-800-772-1213 or visit socialsecurity.gov. TTY users should call 1-800-325-0778. You may need to show proof of an SSN application or reason why an SSN cannot be obtained.

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.):

- Spouse
- Natural, adoptive, or stepchildren under age 19 years old
- Unmarried partner with a shared child
- Any other person on the same federal income tax return (including any children over age 19 who are claimed on a parent's tax return). You don't need to file taxes to get health coverage.
- Other children under your care who are under age 19 years old

For children under age 19 who need coverage, include even if not applying for health coverage:

- Any parent (or stepparent) they live with
- Any sibling they live with
- Any son or daughter they live with, including stepchildren
- Any other person on the same federal income tax return. You don't need to file taxes to get health coverage.

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 1 Start with yourself

Complete Step 2: PERSON 1 for yourself.

1. First name	Middle name	Last name	Suffix	Relationship to PERSON 1 **SELF**
2. Date of birth (mm/dd/yyyy)		3. Gender (Optional) ☐ Male ☐ Female		4. Social Security Number (SSN)
5. Name of spouse if married				

As a condition of eligibility, a Social Security Number (SSN) must be provided for each individual (including children) applying for medical assistance. The SSN will help process the application automatically.

6. 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: _____

7. Are you pregnant? ☐ Yes ☐ No

If yes, how many babies are expected during this pregnancy? _____ Expected Due Date: _____

8. Are you applying for medical assistance? (Even if you have other insurance, there might be a program with better coverage or lower costs.)

☐ Yes. If yes, answer all the questions below (9-19). ☐ No. If no, SKIP to the income questions on page 4.

9. If applying for insurance are you a resident of Hawaii? ☐ Yes ☐ No

10. Does this person have a spouse or parent that lives outside the household? ☐ Yes ☐ No

11. Were you ever in an accident? If so, are you still incurring medical expenses because of it? ☐ Yes ☐ No

Questions for Aged (65 or older), Blind, Disabled/Long-Term Service and Support:

12. 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? _____ ☐ 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

13. Did you receive any medical services in the past three (3) months immediately prior to the date of this application?

☐ Yes. If Yes, what dates? _____ ☐ No

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

15. 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 below:

Immigration document type (i.e. I-551, Visa, etc.)	Status type (optional)
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)

16. Provide the date of entry to the U.S. found on your immigration document listed in question 15. (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

17. Were you in Foster Care, or receiving Kinship or State Adoption assistance and receiving Medicaid when you turned 18 or older? ☐ Yes ☐ No

18. If Hispanic/Latino, ethnicity (**OPTIONAL**: mark all that apply.)

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

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

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

CLEAR FORM

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 20.

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

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

JOB 1: Please enter job income even if your job(s) status changed in the past year from the date of this application.

Check any of the following that have occurred within the last year
☐ Changed jobs ☐ Stopped working ☐ Started working fewer hours ☐ None of these

Start Date: _____ **End Date:** _____

20. Employer name and address:

21. Employer phone number:
( ) –

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

23. Average hours worked each WEEK:

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

Start Date: _____ **End Date:** _____

24. Employer name and address:

25. Employer phone number:
( ) –

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

27. Average hours worked each WEEK:

Please attach proof of your business excise tax license, gross income, and receipts of self-employment expenses to determine net income. If documents are not attached, you will be contacted for the information.

28. 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?
$_____

29. 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, veteran's payment or SSI monthly income

☐ Unemployment $_____How often? _____
☐ Pensions $_____How often? _____
☐ Social Security $_____How often? _____
☐ Retirement accounts $_____How often? _____
☐ Alimony received $_____How often? _____
(If agreement/amended on/before Dec 31, 2018)

☐ Net farming/fishing $_____How often? _____
☐ Net rental/royalty $_____How often? _____
☐ Educational Grant/Work Study $_____
☐ Other Type of income _____
$_____How often? _____

30. DEDUCTIONS: Check all the deductions that can be 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 28b)
☐ Alimony paid $_____How often? _____
(If agreement/amended on/before Dec 31,2018)
☐ Other Type of deductions _____How often? _____
☐ Student loan interest $_____How often? _____

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

Your total income this year:
$

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

If there are more people to include, please make a copy of pages 5 and 6.
Complete and attach additional pages to this application.
If this is not applicable skip to page 7 of 11.

CLEAR FORM

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 2 of 11, Step 2)

1. First name	Middle name	Last name	Suffix	2. Relationship to PERSON 1
3. Date of birth (mm/dd/yyyy)		4. Gender (Optional) ☐Male ☐Female	5. Social Security Number (SSN)	
6. Name of spouse if married				

As a condition of eligibility, a Social Security Number (SSN) must be provided for each individual (including children) applying for medical assistance. The SSN will help process the application automatically.

7. Does PERSON 2 live with PERSON 1? ☐Yes ☐No

8. If No, Home address: _____
(If Homeless, please enter "Homeless" here with appropriate city, state and zip code and mark this box ☐)

9. 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 your 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 are PERSON 2 related to the tax filer: _____

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

11. Is PERSON 2 applying for medical assistance? (Even if you have other insurance, there might be a program with better coverage or lower costs.)
☐Yes. If yes, answer all the questions below (12-22). ☐No. If no, SKIP to the income questions on page 6.

12. If PERSON 2 is applying is he/she a resident or intent to be a resident of Hawaii? ☐Yes ☐No

13. Does PERSON 2 have a spouse or parent that lives outside the household? ☐Yes ☐No

14. Was PERSON 2 ever in an accident? If so, are you still incurring medical expense because of it? ☐Yes ☐No

Questions for Aged (65 or older), Blind, Disabled/Long-Term Service and Support:

15. 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 dates? _____ ☐No

c. Does PERSON 2 need long term care nursing services now? ☐Yes ☐No

d. Does PERSON 2 receive Supplemental Security Income (SSI)? ☐Yes ☐No

16. Did you receive any medical services in the past three (3) months immediately prior to the date of this application?
☐Yes. If Yes, what dates? _____ ☐No

17. Is PERSON 2 a U.S. citizen or U.S. national? ☐Yes ☐No

18. If PERSON 2 is not a U.S. citizen or U.S. national, do they have eligible immigration status? If Yes, enter document type and ID number below:

Immigration document type (i.e. I-551, Visa, etc.)	Status type (optional)
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)

19. Provide the date of entry to the U.S. found on the immigration document listed in question 18. (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, their spouse or parent, a veteran, or an active-duty member of the U.S. military? ☐Yes ☐No

20. Was PERSON 2 in Foster Care, or receiving Kinship or State Adoption assistance and receiving Medicaid when they turned 18 or older? ☐Yes ☐No

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

22. 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:

CLEAR FORM

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 currently employed, tell us about your income. Start with question 23.

☐ **Self-employed**
Skip to question 31.

☐ **Not employed**
Skip to question 32.

JOB 1: Please enter job income even if your job(s) status changed in the past year from the date of this application.

Check any of the following that have occurred within the last year
☐ 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:

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

Start Date: _____ **End Date:** _____

27. Employer name and address:

28. Employer phone number:
( ) –

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

$_____

30. Average hours worked each WEEK:

Please attach proof of PERSON 2's business excise tax license, gross income, and receipts of self-employment expenses to determine net income. If documents are not attached, you will be contacted for the information.

31. 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 PERSON 2 get this month from self-employment?
$_____

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

☐ Unemployment $_____How often? _____

☐ Pensions $_____How often? _____

☐ Social Security $_____How often? _____

☐ Retirement accounts $_____How often? _____

☐ Alimony received $_____How often? _____
(If agreement/amended on/before Dec 31, 2018)

☐ Net farming/fishing $_____How often? _____

☐ Net rental/royalty $_____How often? _____

☐ Educational Grant/Work Study $_____

☐ Other Type of income _____
$_____How often? _____

33. DEDUCTIONS: Check all the deductions that can be filed on PERSON 2's federal income tax return.
NOTE: You should not include a cost that you already considered in your answer to net self-employment (question 31b)

☐ Alimony paid $_____How often? _____
(If agreement/amended on/before Dec 31,2018)

☐ Other Type of deductions _____How often? _____

☐ Student loan interest $_____How often? _____

34. NET YEARLY INCOME: Complete if PERSON 2's net income changes a lot from month to month.
If you do not expect 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 more people to include, please make a copy of STEP 2: PERSON 2 (Pages 5 and 6).
Once completed, attach additional pages to this application and continue to STEP 3

CLEAR FORM

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
- Unmarried Partner or Domestic Partner
- Parent (including step)
- Child (including step)
- Grand Parent
- Grand Child
- Foster Parent
- Foster Child
- Under Primary Care
- Sibling (including step)
- Aunt/Uncle
- Cousin
- Nephew/Niece (including step)
- Other Related (i.e., in law living in home)
- Not Related

Household Member PERSON 1 **Name of Person 1:**

Is Person 1 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 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.

CLEAR FORM

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 filer(s) submitted IRS Form 8962 (healthcare.gov/help/reconciling-your-tax-credit/) with the tax return.**
     - **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 in the last 4 years?
   - ☐ **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.

CLEAR FORM

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

CLEAR FORM

Family Health Coverage PERSON 1	Name:
Type of Coverage(s): ☐ Employer Insurance ☐ COBRA ☐ Medicare ☐ TRICARE ☐ VA health care program ☐ Peace Corps ☐ Other Start Date:_____ End Date: _____	
If it is an employer insurance: *(You will also need to complete Appendix A.)* Name of health insurance company:	Policy/ID number
If it is another kind of coverage: Name of health insurance company:	Policy/ID number
Is this a limited-benefit plan, like a school accident policy? ☐Yes ☐No	Includes: ☐ Medical ☐ Dental ☐ Vision

Family Health Coverage PERSON 2	Name:
Type of Coverage(s): ☐ Employer Insurance ☐ COBRA ☐ Medicare ☐ TRICARE ☐ VA health care program ☐ Peace Corps ☐ Other Start Date:_____ End Date: _____	
If it is an employer insurance: *(You will also need to complete Appendix A.)* Name of health insurance company:	Policy/ID number
If it is another kind of coverage: Name of health insurance company:	Policy/ID number
Is this a limited-benefit plan, like a school accident policy? ☐Yes ☐No	Includes: ☐ Medical ☐ Dental ☐ Vision

Family Health Coverage PERSON 3	Name:
Type of Coverage(s): ☐ Employer Insurance ☐ COBRA ☐ Medicare ☐ TRICARE ☐ VA health care program ☐ Peace Corps ☐ Other Start Date:_____ End Date: _____	
If it is an employer insurance: *(You will also need to complete Appendix A.)* Name of health insurance company:	Policy/ID number
If it is another kind of coverage: Name of health insurance company:	Policy/ID number
Is this a limited-benefit plan, like a school accident policy? ☐Yes ☐No	Includes: ☐ Medical ☐ Dental ☐ Vision

Family Health Coverage PERSON 4	Name:
Type of Coverage(s): ☐ Employer Insurance ☐ COBRA ☐ Medicare ☐ TRICARE ☐ VA health care program ☐ Peace Corps ☐ Other Start Date:_____ End Date: _____	
If it is an employer insurance: *(You will also need to complete Appendix A.)* Name of health insurance company:	Policy/ID number
If it is another kind of coverage: Name of health insurance company:	Policy/ID number
Is this a limited-benefit plan, like a school accident policy? ☐Yes ☐No	Includes: ☐ Medical ☐ Dental ☐ Vision

Family Health Coverage PERSON 5	Name:
Type of Coverage(s): ☐ Employer Insurance ☐ COBRA ☐ Medicare ☐ TRICARE ☐ VA health care program ☐ Peace Corps ☐ Other Start Date:_____ End Date: _____	
If it is an employer insurance: *(You will also need to complete Appendix A.)* Name of health insurance company:	Policy/ID number
If it is another kind of coverage: Name of health insurance company:	Policy/ID number
Is this a limited-benefit plan, like a school accident policy? ☐Yes ☐No	Includes: ☐ Medical ☐ Dental ☐ Vision

Family Health Coverage PERSON 6	Name:
Type of Coverage(s): ☐ Employer Insurance ☐ COBRA ☐ Medicare ☐ TRICARE ☐ VA health care program ☐ Peace Corps ☐ Other Start Date:_____ End Date: _____	
If it is an employer insurance: *(You will also need to complete Appendix A.)* Name of health insurance company:	Policy/ID number
If it is another kind of coverage: Name of health insurance company:	Policy/ID number
Is this a limited-benefit plan, like a school accident policy? ☐Yes ☐No	Includes: ☐ Medical ☐ Dental ☐ 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 section of this page.

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 (DHS) 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) within 10 of days 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.
- For applicants under the age of 19 with an absent parent, acknowledge that you understand the following:
  - You will be asked to cooperate with the Department of Human Services and the agency that collects medical support from an absent parent.
  - You understand that you can tell Medicaid and that you may not have to cooperate if you think that cooperating to collect medical support will harm you or your children or if you are a pregnant woman.
- DHS can 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 information I provide to the DHS services and the Federal Health Insurance Marketplace will be subject to verification with electronic databases, to include but not limited to, the Social Security Administration (SSA), Department of Homeland Security (DHS) or a consumer reporting agency. By signing this application, I authorize DHS to verify my information provided. I also understand that if the information does not match, I may be asked to send Hawaii Med-QUEST Division 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.
- 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

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) or online at https://medical.mybenefits.hawaii.gov/appeals.html .

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, or acting responsibly on a behalf of an applicant who is incapacitated or a minor, sign here and you must complete Appendix C.

CLEAR FORM

First Name, Last Name:	
Signature	Date (mm/dd/yyyy)

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.

STEP 7 How to provide us your signed Medicaid Application:

Statewide	**Med-QUEST Eligibility & Enrollment Service Centers** **1-800-316-8005 (Phone)** **711 TTY/TDD (Available to deaf, hearing, and speech impaired)** **1-800-576-5504 (Fax)** **MQDCustomerSupport@dhs.hawaii.gov (Email)** **P.O. Box 3490, Honolulu, HI 96811-3490 (Mailing)**
HAWAIʻI	**Hilo Service Center** 1404 Kilauea Avenue, Hilo, HI 96720 **Kona Service Center** Lanihau Professional Center, 75-5591 Palani Road, Suite 3004, Kailua-Kona, HI 96740
KAUAʻI	**Kaua'i Service Center** Dynasty Court, 4473 Pahee Street, Suite A, Lihue, HI 96766
MAUI	**Maui Service Center (Maui County)** Maui Millyard Plaza, 210 Imi Kala Street, Suite 101, Wailuku, HI 96793 Molokaʻi State Civic Center, 65 Makaena Street, Room 110, Kaunakakai, HI 96748 Lanaʻi 730 Lanaʻi Avenue, Lanaʻi City, HI 96763
OAHU	**Oahu Service Center** Honolulu 1350 South King Street, Suite 200, Honolulu, HI 96814 Kapolei 601 Kamokila Boulevard, Room 415, Kapolei, HI 96707 Waipahu 94-275 Mokuola Street, Suite 301, Waipahu, HI 96797

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

CLEAR FORM

Earned Income Tax Credit (EITC):

EITC is a benefit for working people who have low to moderate income. This tax credit reduces the amount of tax you owe and may also result in a refund. You must understand that you have to report income changes because it may affect the amount of premium assistance (or tax credits) you may be eligible to receive. If you receive too much premium assistance (or tax credits) during the benefit year, you will need to pay the extra premium assistance back to the IRS when filing for federal income taxes for the benefit year.

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 even if they don't accept the coverage. 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): A health plan meets the minimum value standard if it pays at least 60% of the total cost of medical services for a standard population and offers substantial coverage of hospital and doctor services. Most job-based plans meet the minimum value standard.

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)

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.

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**

CLEAR FORM

(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)

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 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?_____

CLEAR FORM

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 C

CLEAR FORM

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)

The household contact/Person 1 will need to sign Appendix C, if you or another household member are designating an authorized representative. The authorized representative is allowed to get official information about this application, and act for you on all future matters with this agency.

☐ Please select this box if the individual who is signing below is the Applicant.

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.

CLEAR FORM

APPENDIX C (Continued)

Person Acting Responsibly (for this application only)

If you are a minor, incapacitated, or a Limited English Proficient (LEP), you can give someone permission to act responsibly to help you fill out this application.

1. Name of person acting responsibly on your behalf (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 ( ) –			

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 (Applicant/Beneficiary) or Primary Individual's Signature	12. Date (mm/dd/yyyy)

Signature of Person Acting Responsibly

I understand that by acting responsibly I may complete, sign under penalty of perjury, and submit an application on behalf of an applicant if they are a minor or incapacitated. I agree to maintain the confidentiality of any information provided to me by the Department or it's designee, assist with providing all required proof of information necessary to determine eligibility for benefits and speak on the applicant/beneficiary behalf if the application decision is appealed. I understand that I can also be released at any time by PERSON 1 (Applicant/Beneficiary) or Primary Individual listed above.

Signature of Person Acting Responsibly on PERSON 1 behalf

Date

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

CLEAR FORM

STATE OF HAWAII
NATIONAL VOTER REGISTRATION ACT QUESTIONNAIRE

If you are not registered to vote where you live now, would you like to apply to register to vote here today?

☐ **Already registered** I am registered to vote at my current residence address.

☐ **YES** I would like to register to vote. (Please fill out the *Voter Registration Application*.)

☐ **NO** I do not want to register to vote.

If you do not check a 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 application, we will help you. The decision to seek or accept help is yours. You may fill out the application in private.

If you believe that someone has interfered with your right to register or to decline to register to vote, or your right to privacy in deciding whether to register or in applying to register to vote, you may file a complaint with the Office of Elections by phone (808) 453-VOTE (8683) or toll free at 1-800-442-VOTE (8683) or by mail to Office of Elections, 802 Lehua Avenue, Pearl City, Hawaii 96782.

_____
Print Name

_____ _____
Signature Date

Office Use Only	☐ Applicant declined to sign questionnaire	State Agency ID: A017

Estado ti Hawaii
Listaan Dagiti Saludsod iti Babaen ti Linteg ti Nailian a Rehistrasion ti Botante

No saanka a rehistrado nga agbotos iti lugar a pagnaedam ita, kayatmo kadi ti agaplikar nga agparehistro a kas botante iti daytoy a lugar ita met laeng?

☐ **Nakapagparehistroakon** Rehistradoak nga agbotos iti agdama nga adres ti residensiak.

☐ **Wen** Kayatko ti agparehistro nga agbotos. (Kompletuen ti Aplikasion ti Rehistrasion ti Botante.)

☐ **Saan** Diak kayat ti agparehistro nga agbotos.

No awan ti tsekam a kahon, maikonsiderarka nga inkeddengmo ti saan nga agparehistro nga agbotos iti daytoy a gundaway.

Napateg a Pakaammo

Ti panagaplikar nga agparehistro wenno panagkedked nga agparehisto tapno makapagbotos ket saan a makaapektar iti kaadu ti tulong a maipaay kenka daytoy nga ahensia.

No kasapulam ti tulong iti panangkompletom iti aplikasion ti rehistrasion ti botante, tulongandaka. Ti desision nga agkiddaw wenno umawat iti tulong ket agpannuray kenka. Mabalinmo a kompletuen ti aplikasion a siksika.

No patiem nga adda nangbiang iti kalintegam nga agparehistro wenno agkedked nga agparehistro nga agbotos, wenno iti karbengam iti kinapribado (privacy) iti panangikeddeng no agparehistroka wenno iti panagaplikarmo nga agparehistro nga agbotos, mabalinmo ti mangipila iti reklamo iti Opisina Dagiti Eleksion (Office of Elections) babaen ti yaawagmo iti (808) 453-VOTE (8683) wenno iti libre a pagawagan (toll free) iti 1-800-442-VOTE (8683) wenno babaen ti koreo iti Office of Elections, 802 Lehua Avenue, Pearl City, Hawaii 96782.

_____
Iprinta ti Nagan

_____ _____
Pirma Petsa

Office Use Only	☐ Applicant declined to sign questionnaire	State Agency ID: A017

夏威夷州
全國選民登記法問卷

如果您沒有在現居地登記投票，今天要在此申請登記投票嗎？

☐ **已經登記** 我已在我目前的居住地址登記投票。

☐ **是** 我想登記投票。（請填寫選民登記申請表。）

☐ **否** 我不想登記投票。

如果您沒有勾選，將被視為決定此次不登記投票。

重要通知

申請登記或拒絕登記投票都不會影響該機構將提供給您的援助金額。

如果您需要幫忙填寫選民登記申請表，我們將提供您協助。您可自行決定是否尋求或接受幫忙。您可以私下填寫申請表。

如果您認為有人干涉了登記或拒絕登記投票的權利，或是決定是否登記或申請登記投票時的隱私權，您可以撥打電話向選舉辦公室提出申訴（808）453-VOTE (8683) **或免費電話** 1-800-442-VOTE（8683）**或郵寄至** 96782 **夏威夷珍珠城** Lehua Avenue 802 **號的選舉辦公室**

_____
正楷姓名

_____ _____
簽名 **日期**

Office Use Only	☐ Applicant declined to sign questionnaire	State Agency ID: A017

ESTADO NG HAWAII
TALATANUNGAN NG BATAS SA PAGPAPAREHISTRO NG PAMBANSANG BOTANTE

kung ikaw ay hindi pa naka rehistro na bumoto kung saan ikaw ay kasalukuyang nakatira, gusto mo bang mag apply para magparehistro dito ngayon?

☐ **Nakarehistro na** Ako ay nakarehistro upang bumoto sa aking kasalukuyang address.

☐ **Oo** Gusto kong magparehistro para bumoto. (Pakiusap na i fill out ang Aplikasyon sa Pagpaparehistro ng Botante.)

☐ **Hindi** Ayokong magparehistro para bumoto.

Kung hindi mo lagyan ng check ang box, ikaw ay itinuturing na nagpasya na huwag magparehistro para bumoto sa oras na ito.

Mahalagang Paunawa

Ang pag-aplay para magparehistro o pagtanggi na magparehistro para bumoto ay hindi maka-kaapekto sa halaga ng tulong na ibibigay sayo ng ahensya na ito.

Kung gusto mo ng tulong sa pagsagot sa aplikasyon sa pagpaparehistro ng botante, tutulungan ka namin. Ang desisyon na humingi o tumanggap ng tulong ay nasa iyo. Maaari mong punan ang aplikasyon ng pribado.

Kung naniniwala kang may humadlang sa iyong karapatang magparehistro o tumanggi na magparehistro para bumoto, o ang iyong karapatan sa pribado sa pagpapasya kung magparehistro o sa pag aaplay para magparehistro para bumoto, maaari kang magsampa ng reklamo sa Office of Elections sa telepono (808) 453-VOTE (8683) o walang bayad sa 1-800-442-VOTE (8683) o by mail sa Office of Elections, 802 Lehua Avenue, Pearl City, Hawaii 96782.

_____
Print Name o Pangalan

_____ _____
Signature 0 Lagda Date o Petsa

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Hawaii Voter Registration Application

Please print clearly in black ink.

Register online at **elections.hawaii.gov**

1 **Do you meet these qualifications:**

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? ☐ Yes ☐ No

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

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 If you are disabled and unable to read standard print, would you like to receive an electronic ballot?

☐ Yes. I am disabled and unable to read standard print and would like to request an electronic ballot be sent to my email indicated on this application. **Applicant must provide an email address to receive an electronic ballot.**

6 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).

7 **Are you registered to vote in another state?** ☐ Yes. I hereby authorize cancellation of my previous registration at the following address, county, state, and zip code.

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 their 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 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).

HAWAII VOTES

Voter Registration Application

This application can be used for:

- First time registration
- Name change
- Address change
- Signature update

Hawaii Votes by Mail

All registered voters will be automatically sent a ballot to their mailing address in Hawaii associated with their voter registration.

First time Voter Mailing this Application

If you are registering to vote for the first time in the State of Hawaii, mailing this application, and do not have a Hawaii Driver License, Hawaii State ID, or the last 4-digits of your 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 Your Application

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

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

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

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

Language Assistance

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)**.

Para sa mga isinalin na babasahin tungkol sa eleksyon o upang makatanggap ng tulong sa wika sa pagkumpleto ng aplikasyon na ito, makipag-ugnayan sa Tanggapan ng mga Eleksyon **(Office of Elections)**.

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)**.

Contact Us

For information about registering to vote, contact your **County Elections Division**.

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**.

Phone: (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: elections.hawaii.gov