IF YOU WANT TO APPLY FOR:
FINANCIAL, SNAP & MEDICAL ASSISTANCE **use addresses below**
FOR SNAP ONLY **use addresses below**
FOR QUEST/MEDICAL ONLY **see addresses on last page of application**

Hawaii Kai to Kalihi (includes airport area for homeless)**:**

Pauahi Unit (Room 201) or Iwilei Unit (Room 200)
333 N. King St.
Honolulu, HI 96817

Pauahi Unit telephone: 586-8108 Fax: 586-7328
Iwilei Unit telephone: 586-8047 Fax: 586-8138

Waimea to Waimanalo:

Kailua Unit
45-513 Luluku Road
Kaneohe, HI 96744

Telephone: 233-5325 Fax: 233-5358

Waialua,Wahiawa, Makaha through Waipahu (Eff. 9/12/11):

1. Kamokila Unit (Accepts applications for A through K)
   601 Kamokila Blvd., Room 468
   Kapolei, HI 96707

   Telephone:692-7171 Fax: 692-7179

2. Ewa Unit (Accepts applications for L through Z)
   601 Kamokila Blvd., Room 106
   Kapolei, HI 96707

   Telephone: 692-7300 Fax: 692-7318

Haleiwa, Mililani, Waipio Gentry, Waikele, Pearl City through Salt Lake (includes Halawa), and Airport area (Eff. 9/12/11):

West Oahu Unit
94-275 Mokuola St., Rm. 303A
Waipahu, HI 96797

Telephone: 675-0050 Fax: 675-0038

WHAT IS TEMPORARY ASSISTANCE FOR NEEDY FAMILIES?

Temporary Assistance for Needy Families (TANF) is a federal and State funded program run by the Department of Human Services (DHS), Benefit, Employment and Support Services Division. The program was first implemented in 1997 as a result of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996. There are four TANF purposes.

PURPOSE ONE

"To provide assistance to needy families"

- Direct cash payment to the family
- Self-Sufficiency Program
- Income Disregard
- Financial Counseling

All programs are subject to established eligibility criteria that will be explained to you by your DHS worker

PURPOSE TWO

"To end dependence of needy parents by promoting job preparation, work and marriage"

TANF applicants and recipient are referred to the Department's First-to-Work program to prepare for self-sufficiency.
An assigned case manager will help you reach your employment goals with any of the following activities and services:

- Job Search and Job Preparedness
- Subsidized/Unsubsidized Employment
- GED Prep & Skill Training
- Vocational Education
- On-the Job Training
- Child Care Subsidies
- Transportation Assistance
- Work-Related Expenses
- Domestic Violence Services
- Housing Placement Services
- Employment Bonuses
- On-Going Counseling & Support

PURPOSE THREE

"To prevent and reduce out-of-wedlock pregnancies"

DHS has partnered with a wide variety of community agencies to provide Hawai`i families with programs designed to help prevent teen pregnancies. These programs include:

- After-School Programs
- Family Literacy
- Youth Abstinence
- Family Strengthening
- Positive Youth Development

PURPOSE FOUR

"To encourage the formation and maintenance of two-parent families."

Programs intended to teach the skills necessary to build strong families are made available by DHS and include:

- Fatherhood Services
- Marriage/Couples Counseling
- Parenting Skills
- Home-Based Parenting & Family Counseling

WHERE TO APPLY?

You may apply for TANF benefits at a Benefit, Employment and Support Services Office. Call the Public Assistance Information Line.

643-1643

STATE OF HAWAII
DEPARTMENT OF HUMAN SERVICES

BENEFIT, EMPLOYMENT, AND SUPPORT SERVICES DIVISION | MED-QUEST DIVISION

IMPORTANT INFORMATION WHEN APPLYING FOR PUBLIC ASSISTANCE PROGRAMS

The attached application form is a two-part, white and canary form. The white form (DHS 1240) is an application for financial and SNAP assistance. The canary form (DHS 1100) is an application for medical assistance.

IF YOU ARE APPLYING FOR:	YOU NEED TO COMPLETE:
Financial Assistance and Medical Coverage	White and canary forms (Signatures required on page 1, 3 and 11 of the white form and on page 6 of the canary form).
Supplemental Nutrition Assistance Program (SNAP) only (formerly the Food Stamp Program)	White form (Signatures required on page 1, 3 and 11 of the white form).
Financial, SNAP and Medical Coverage	White and canary forms (Signatures required on page 1, 3 and 11 of the white form and on page 6 of the canary form).
Medical Coverage Only	Canary form (Signatures required on page 6 of the canary form).
SNAP and Medical Coverage	White and canary forms (Signatures required on page 1, 3 and 11 of the white form and page 6 of the canary form).

Information about the TANF Program and other programs available under the Department of Human Services can be found at the following website:
http://hawaii.gov/dhs/quicklinks/What Is TANF

STATE OF HAWAII
Department of Human Services
BENEFIT, EMPLOYMENT, AND SUPPORT SERVICES DIVISION

APPLICATION FOR FINANCIAL AND SNAP ASSISTANCE

FOR OFFICIAL USE ONLY		
CASE NAME		
CATEGORY/CASE NUMBER	BRANCH	UNIT
WORKER CODE	WORKER'S NAME	PHONE
☐ FORM MAILED ☐ GIVEN	DATE	

APPLICATION FILING: The day your application is received is the date from which your eligibility for benefits will be determined. Benefits will be paid from that filing date if you are eligible. If you are unable to fill out the application now, just complete your name, address and signature below and turn it in. You must still answer the rest of the questions on the application form before benefits are issued. If you cannot complete the application the eligibility worker will help you. If you are currently residing in a public institution and will be released within 30 days, you may file your application today but the date of application will be the day of release from the institution.

DATE SIGNED FORM RETURNED

PLEASE PRINT CLEARLY

I would like to apply for the following types of benefits: ☐ Money ☐ Supplemental Nutrition Assistance Program (SNAP)

YOUR NAME (Last, First, M.I.)	YOUR SOCIAL SECURITY NO.	BIRTHDATE	PHONE NO.
SPOUSE'S NAME (Last, First, M.I.)	SPOUSE'S SOCIAL SECURITY NO.	SPOUSE'S BIRTHDATE	MESSAGE PHONE NO.

ADDRESS WHERE YOU LIVE (NUMBER AND STREET OR DIRECTIONS TO YOUR HOME)	APT/SPACE NO.	CITY & STATE	ZIP CODE	MILITARY BASE (IF RESIDING IN BASE HOUSING)
YOUR MAILING ADDRESS (IF DIFFERENT FROM ABOVE NUMBER AND STREET)	APT/SPACE NO.	CITY & STATE	ZIP CODE	

HOW MANY PERSONS PURCHASE FOOD AND PREPARE MEALS WITH YOU? (INCLUDE YOURSELF)	HOW MANY PERSONS DO NOT PURCHASE FOOD AND PREPARE MEALS WITH YOU?	ARE THEY RELATED TO ANYONE IN YOUR HOUSEHOLD? ☐ YES ☐ NO	HOW MANY CHILDREN LIVE WITH YOU?

IS ANYONE IN YOUR HOME PREGNANT? ☐ YES ☐ NO	IF YES, INDICATE WHO NAME:	WHEN IS THE BABY DUE? DATE:

SIGNATURE OR MARK OF ADULT APPLICANT _____ DATE _____

SIGNATURE OR MARK OF SPOUSE OR OTHER ADULT APPLICANT _____ DATE _____
(This signature is required for Money Assistance only)

WITNESS IF SIGNATURES ARE "X" _____ DATE _____

APPOINTMENT NOTICE: When your application is received, an Appointment Notice for your interview will be sent or given to you. You must be interviewed before you can receive benefits. A telephone interview may be conducted in lieu of an office interview for aged, disabled or working individuals or for others in hardship situations. To shorten the processing time, you should bring to the interview written proof of information and verification as noted on your appointment letter. You may be asked at the interview to bring more information. If you miss your appointment, or need to change it, you must call the local office to reschedule. The following action will be taken if you miss your appointment:

- For SNAP, if you do not reschedule by the 30th day from the day you filed your application or the last day of your certification, your application will be denied. If your application is denied, you may be required to reapply to receive benefits. You may lose benefits for failing to appear at your interview.
- For cash benefits, if you do not reschedule your appointment date, your application will be denied within the time limits specified by our policies. If you are currently receiving benefits, they may be stopped if you do not reschedule the missed appointment. If benefits are denied or stopped, you may reapply if you still want benefits.

AFTER YOUR INITIAL INTERVIEW WE ENCOURAGE YOU TO REPORT CHANGES AS SOON AS THEY HAPPEN, THIS MAY PREVENT ANY DELAYS IN BENEFITS TO YOU.

INTERVIEW INFORMATION: An interview must be completed before you can receive help. A single interview is sufficient when applying for SNAP and financial benefits. Appointments are scheduled according to the date you apply, with the earliest application given the first available appointment. You will be notified of the date and time of your appointment. EXCEPTION: If you meet the EMERGENCY ASSISTANCE requirements, you will be interviewed and provided financial benefits within two (2) working days and/or SNAP within seven (7) calendar days from the date of application. Answer the EMERGENCY ASSISTANCE questions below only if you need help right away.

YOU MAY GET SNAP WITHIN SEVEN (7) CALENDAR DAYS IF YOUR HOUSEHOLD:

- Monthly rent/mortgage and utilities are more than your household's gross monthly income and liquid resources; or
- Gross monthly income is less than $150 and your household's liquid resources, such as cash or checking/savings accounts, are $100 or less; or
- Is a seasonal farmworker household whose income terminated prior to applying, is not expecting income of $25 within the next 10 days and has liquid assets of less than $100.

CHECK THE BOX FOR EACH TYPE OF EMERGENCY ASSISTANCE YOU ARE APPLYING FOR: ☐ Financial ☐ SNAP

YES	NO	
☐	☐	Is anyone in your home a seasonal farm worker whose only source of income for the month terminated before applying and income of less than $25 is expected within the next 10 days?
☐	☐	Does anyone in your home have cash or savings or bank accounts? If yes, how much? _____
☐	☐	Has anyone in your home received money this month? If yes, how much? _____
☐	☐	Does anyone in your home expect to receive any money this month? If yes, how much? _____ When? (Date) _____
☐	☐	Are you currently paying any of the following shelter expenses? If yes, list the amounts: Rent/Mortgage _____ Electric _____ Gas _____ Water _____ Phone _____
☐	☐	Have you been served court papers to get out of your present living arrangements? (Attach papers)
☐	☐	Are you living in an agency temporary facility and have to get out in five days? If yes, name of facility? _____

Refer to codes below for responses to questions marked with the corresponding asterisk symbols (*)

1. HOUSEHOLD MEMBERS

On line #1, enter the name of the primary person who will receive the money and/or SNAP benefits for your household. If spouse is in the household, list spouse on line #2. Then list the other household members who are applying for assistance. For money assistance applicants, if anyone in the home is pregnant, list "unborn child" as a household member. All other household members not applying for assistance shall be listed under section #2.

Last Name, First, M.I.	SEX M/F	(*) RELATIONSHIP	(*) TO PERSON #1	BIRTHDATE MO/DAY/YR	SOCIAL SECURITY NUMBER (42 USC 1320b-7 requires that SSN's be provided for each household member applying for assistance.)	(**) ETHNIC	(***) RACE	(****) MARITAL	(****) STATUS	YES or NO DISABLED	HIGHEST GRADE	COMPLETED	NAME OF CHILD'S PARENT(S) IF NOT IN THE HOME	Was child's mother married to child's father at time of birth? (Check one) Yes	No
1.															
OTHER NAMES USED				AGE:											
2.															
OTHER NAMES USED				AGE:											
3.															
OTHER NAMES USED				AGE:											
4.															
OTHER NAMES USED				AGE:											
5.															
OTHER NAMES USED				AGE:											
6.															
OTHER NAMES USED				AGE:											
7.															
OTHER NAMES USED				AGE:											
8.															
OTHER NAMES USED				AGE:											

2. HOUSEHOLD MEMBERS WHO DO NOT WANT HELP

Write in the names of others in your home who do not want assistance (include yourself if you do not need help.) These people do not need to give us information about their citizenship, immigration status or social security number. These people will not be considered applicants and will not be eligible, however, they may need to tell us about their income and answer the other questions on this form.

1.			AGE:
2.			AGE:
3.			AGE:
4.			AGE:

3. Is anyone temporarily out of the home? ☐ **Yes** ☐ **No**

Name	Date Left	Date to Return	Where Person Went

(*) Relationship Codes to Person #1:

SP - Spouse	**GR** - Grandparent	**EX** - Ex-Spouse
PA - Parent	**GC** - Grandchild	**SS** - Step Sibling
CH - Child	**NR** - Not Related	**ST** - Step Parents
SI - Sibling	**OR** - Other Related	**CL** - Common Law
AU - Aunt/Uncle	**UB** - Unborn	**CO** - Cousin
NN - Niece/Nephew	**FC** - Foster Child	**SC** - Step Child

(**) Ethnic Codes - Select only one code

HI - Hispanic
NH- Not Hispanic

(***) Race Codes - Select one or more codes below

WH - White	**JA** - Japanese
BL - Black	**KO** - Korean
AI - American Indian or Alaskan Native	**CH** - Chinese
	FI - Filipino
HA - Hawaiian	**OA** - Other Asian
SA - Samoan	**OP** - Other Pacific Islanders

(This question is optional to answer. Failure to answer will not affect eligibility)

(***) Marital Status Codes:

NM - Never Married
ML - Married, Living With Spouse
DI - Divorced
LS - Legally Separated
MS - Separated
MI - Married, Involuntary Separation
WI - Widowed
CL - Common Law

FINANCIAL APPLICANT'S REPRESENTATIVE

I permit the following individual to be my representative TO APPLY FOR FINANCIAL (CASH) ASSISTANCE on my behalf, as I am unable to do so myself (elderly, handicapped, foster child, etc.). Enter the name and address of applicant's representative below.

Representative's Name (Last, First, M.I.)	Representative's Address (Number, Street, Apt., City, State, Zip Code)	Phone No.

SNAP AUTHORIZED REPRESENTATIVES

I permit the following individual to be my representative TO APPLY FOR SNAP assistance on my behalf.
(Include individual's name or the licensed alcohol or drug treatment facility or group living arrangement representative.)

Representative's Name (Last, First, M.I.)	Representative's Address (Number, Street, Apt., City, State, Zip Code)	Phone No.

ELECTRONIC BENEFIT TRANSFER AUTHORIZED REPRESENTATIVE

I permit the following individual to HAVE ACCESS TO MY CASH ASSISTANCE. [ ] Yes [ ] No
I permit the following individual to HAVE ACCESS TO MY SNAP BENEFITS and to purchase my food. [ ] Yes [ ] No
This representative will be issued an EBT card and PIN (personal identification number). (Include the individual's name or the licensed alcohol or drug treatment facility or group living arrangement representative. The date of birth and social security number will be used for security purposes only.)

Representative's Name (Last, First, M.I.)	Date of Birth	Social Security Number

Representative's Address (Number, Street, Apt., City, State, Zip Code)	Phone No.

QUESTIONS 4 THROUGH 35 ARE TO BE ANSWERED FOR ONLY THOSE WHO ARE APPLYING FOR ASSISTANCE.

4. Is anyone a disabled U.S. veteran or a disabled spouse or a child of a deceased U.S. veteran? ☐ Yes ☐ No
   If yes, name: _____

5. Is anyone (including children) disabled? ☐ Yes ☐ No If yes, name of disabled person(s):
   _____
   They could be eligible for Supplemental Security Income (SSI) or SSA Disability or Blindness benefits.

6. Is anyone in the household fleeing a felony warrant for arrest; a parole/probation violator; or been convicted of a Federal or State felony for possession, use or distribution of illegal drugs? ☐ Yes ☐ No If yes, name(s): _____

7. CITIZEN STATUS DECLARATION. Pursuant to 42 USC 1320b-7, one applicant household member must certify under penalty of perjury the citizenship status of each applicant household member. If you are not applying for benefits, we will not share your name and information with the Immigration and Naturalization Service (INS). However, information may be shared with the INS to verify the immigration status of persons applying for aid. **I CERTIFY UNDER PENALTY OF PERJURY THAT THE INFORMATION BELOW ON EACH APPLICANT HOUSEHOLD MEMBER IS CORRECT.**

   Signature of Adult Applicant/Representative: _____ Date: _____

(CHECK ONE)					COMPLETE IF YOU ARE A NON-U.S. CITIZEN						
Name	US	US Nat'l	Non-US Cit.	Birthplace	Date of Entry	Immigration Status	Effective Date Of Status	INS Form or Alien Registration Number	Do you, your spouse, or parent have 40 qtrs. of work? (Y/N)	Veteran or Active Military? (Y/N)	Spouse or Dep. Child of Veteran or Act. Military? (Y/N)

NOTE: If you are a permanent alien, you will be required to provide verification of work history.

8. If sponsored non-U.S. citizen or refugee, give name, address, and phone number of the sponsor(s).

Name	Address	Phone

9. What is the primary language spoken in your home? _____

How well is English spoken in the home? (Check only one box)

☐ Does not speak or understand English
☐ Limited understanding
☐ Speaks well, does not read or write English
☐ Speaks well, limited reading and writing skills
☐ Speaks well, adequate reading and writing skills

Do you need an interpreter? If needed, an interpreter will be provided free of charge.

☐ Yes. What language: _____
☐ No. I will provide my own interpreter or have a family member or friend who can interpret for me.

10. Has anyone ever received financial or SNAP assistance? ☐ Yes ☐ No

NAME	Type of Assistance	Date Last Received	County/State Last Received

11. Has any household member been disqualified from the SNAP or financial assistance programs?
☐ Yes ☐ No If yes, list name, program, disqualification period, county and state.

NAME	PROGRAM	DISQUALIFICATION PERIOD	COUNTY/STATE

12. For SNAP applicants/recipients only: if you are age 18 through 49, and are an able-bodied adult without dependents (ABAWD), you will only be eligible for three months of assistance in a 36-month period unless you meet additional work/training requirements. You must be employed or participating in an eligible work/training program for 20 hours weekly. Have you participated in a job training program under the Employment and Training (E&T) program, Workforce Investment Act or Trade Adjustment Assistance Act? ☐ Yes ☐ No

NAME	Job or Training Program	Participation Dates

13. Is anyone on strike? ☐ Yes ☐ No If yes, name? _____

14. List the person(s) who is needed in the home to care for a disabled person. _____

15. Does anyone have any of the items listed below? Include assets owned as of the first of the month and assets which are co-owned with anyone who does not live with you. Check "Yes or No" for each item. Include other assets not listed in blank spaces provided below.

FINANCIAL ACCOUNTS

YES	NO	ASSETS	NAME OF PERSON(S) ON ACCOUNT	NAME OF FINANCIAL INSTITUTION & BRANCH	ACCOUNT NO.	AMOUNT
		Checking Accounts: Personal/Business				$
		Savings Accounts				$
		Credit Union Accounts				$
		Christmas Savings				$
						$
						$
						$

LIQUID ASSETS

YES	NO	ASSETS	NAME OF PERSON(S) ON ACCOUNT	NAME OF FINANCIAL INSTITUTION & BRANCH	ACCOUNT NO.	AMOUNT
		Cash on Hand				$
		Tax Refund/Tax Credit				$
		Stocks/Bonds (savings bonds)				$
		Money Market/ Time Certificate				$
		IRA/KEOGH Deferred Comp.				$
						$
						$

OTHER ASSETS

YES	NO	ASSETS	PERSON(S) LISTED AS OWNERS	LOCATION/ADDRESS OF ITEM	MARKET VALUE	AMOUNT OWED	EQUITY
		Your Home/Mobile Home			$	$	$
		Other Houses/Land/ Buildings			$	$	$
		Agreement of Sale of Real Property			$	$	$
		Burial Plans/Cemetary Plot			$	$	$
		Life Insurance-List all Policies			$	$	$
		Other (Specify, i.e. Jewelry, TV, Radio, Stereo, Musical Instruments, Hobby Items, Etc.)			$	$	$
					$	$	$

TRANSFER OF PROPERTY

16. Has anyone sold, traded, transferred or given away money, vehicles, property, or other resources/assets in the last 3 months (if applying for SNAP only), or in the last 24 months (if applying for financial assistance)?
☐ Yes ☐ No If yes, complete below:

ITEM SOLD, TRADED, ETC.	DATE	REASON FOR SELLING, TRANSFERRING, ETC.	ACTUAL VALUE OF ITEM	AMOUNT OWED	AMOUNT RECEIVED
			$	$	$
			$	$	$
			$	$	$
			$	$	$
			$	$	$

STUDENT INFORMATION

17. Is anyone aged 16 years and older a student? ☐ Yes ☐ No If yes, complete below:

NAME OF STUDENT	NAME OF SCHOOL	FULL TIME?	PART TIME?	START DATE MO./DAY/YR.	END DATE MO./DAY/YR.

18. Has anyone applied for admission to a college, training, or vocational school? ☐ Yes ☐ No Name: _____

UNEARNED INCOME

19. Is anyone receiving, expect to receive, or have an application pending for any type of income listed below? Check "Yes or No" for each source of income. If "Yes" is checked, complete the information about the item.

YES	NO	PEND-ING	SOURCE OF INCOME	PERSON WHO RECEIVES INCOME	MONTHLY AMOUNT	HOW OFTEN RECEIVED? (MONTHLY/WEEKLY)
			Social Security		$	
			Supplemental Security Income (SSI)		$	
			Assistance Payments from Another State		$	
			Unemployment Benefits		$	
			Housing Authority (HUD, Section 8), Energy Assistance		$	
			Child Support, Alimony		$	
			Money from friends, relatives, charities, contributions, gifts, etc.		$	
			Blood/Plasma income		$	
			Interest/Dividends/Royalties		$	
			Veteran's Benefits, Railroad Retirement, other Governmental Benefits		$	
			Retirement/Pension, Profit Sharing, Annuity Pmts.		$	
			Temporary Disability Insurance/Worker's Compensation		$	
			Training Allowance, Vocational Rehabilitation, JTPA		$	
			Foster Care Payments		$	
			Strike Pay		$	
			Military Enlistment Bonus		$	
			Military Allotment		$	
			Money from land/building sales, rentals or leases (to include agreement of sales)		$	
			Prizes, Cash, Gifts, Awards		$	
			Insurance Settlements		$	
			Reapplication or Appeal of a Denied Benefit (such as SSI or Unemployment benefits, etc.)		$	
			Other (Specify)		$	

EARNED INCOME

20. Give record of all places where you have worked. (Begin with most recent job)

Name, Address, and Phone Number of Employer	From: Mo/Day/Yr.	to: Mo/Day/Yr.	Reason for Leaving	Date(s) Last Paid
Applicant: 1.				
2.				
3.				
Spouse: 1.				
2.				
3.				

21. Is anyone working? ☐ Yes ☐ No If Yes, complete and bring verification to the interview.

PERSON EMPLOYED	JOB TITLE
EMPLOYER	DATE STARTED
ADDRESS	PHONE

HOW OFTEN PAID	PAYDAY	HOURS WORKED PER WEEK	HOURLY RATE OF PAY	GROSS PAY PER CHECK	TIPS PER MONTH
				$	$

PERSON EMPLOYED	JOB TITLE
EMPLOYER	DATE STARTED
ADDRESS	PHONE

HOW OFTEN PAID	PAYDAY	HOURS WORKED PER WEEK	HOURLY RATE OF PAY	GROSS PAY PER CHECK	TIPS PER MONTH
				$	$

PERSON EMPLOYED	JOB TITLE
EMPLOYER	DATE STARTED
ADDRESS	PHONE

HOW OFTEN PAID	PAYDAY	HOURS WORKED PER WEEK	HOURLY RATE OF PAY	GROSS PAY PER CHECK	TIPS PER MONTH
				$	$

22. Is anyone self employed, earning money from a business, baby-sitting, out of home sales, repairing cars, swap meets, garage sales, arts,crafts, etc? ☐ Yes ☐ No If Yes, complete the following and bring verification to the interview.

SELF-EMPLOYED PERSON	TYPE OF BUSINESS	HOURS WORKED PER WEEK	MONTHLY GROSS	MONTHLY EXPENSES
			$	$
			$	$

23. Does anyone receive money from roomers or boarders? ☐ Yes ☐ No If Yes, complete the following:

ROOMER'S/BOARDER'S NAME	MONTHLY AMOUNT RECEIVED	
	ROOM	BOARD
	$	$
	$	$
	$	$

24. Does anyone expect a change in income (such as a new job, a change in wages, etc.)? ☐ Yes ☐ No If Yes, complete the following:

NAME OF PERSON	EXPLAIN	DATE OF CHANGE

COMPLETE FOR SNAP ONLY
DEDUCTIBLE EXPENSES

EXPENSES ARE USED AS A DEDUCTION IN THE DETERMINATION OF THE AMOUNT OF SNAP YOUR HOUSEHOLD MAY BE ENTITLED TO RECEIVE. FAILURE TO REPORT OR VERIFY EXPENSES WILL BE SEEN AS A STATEMENT BY YOUR HOUSEHOLD THAT YOU DO NOT WANT TO RECEIVE A DEDUCTION FOR THE UNREPORTED OR UNVERIFIED EXPENSE. TO CLAIM EXPENSES IN THE FUTURE YOUR HOUSEHOLD WILL NEED TO REPORT AND VERIFY EXPENSES.

SHELTER EXPENSES

25. Does any person or agency outside your household help pay for or provide, at no cost to you, any of the expenses listed below?
☐ Yes ☐ No If Yes, (✓) the expense(s):
☐ Rent ☐ Utilities ☐ Taxes ☐ Mortgages ☐ Personal Supplies ☐ Food ☐ Household Supplies
☐ Medical Care ☐ Clothing ☐ Other _____
If Yes, what person or agency helps pay or provide the expense(s)? _____
Do you need to pay them back? ☐ Yes ☐ No

26. Is anyone in your household working off any part of the rent? ☐ Yes ☐ No If Yes, indicate amount $ _____
27. Do you live in Public Housing? ☐ Yes ☐ No
28. Check Yes or No and complete information for each item:

YES	NO	ITEM	HOW OFTEN BILLED (Monthly, Weekly)	CURRENT BILLED AMOUNT	YES	NO	ITEM	HOW OFTEN BILLED (Monthly, Weekly)	CURRENT BILLED AMOUNT
		Rent					Gas		
		Boat Slip					Propane, Kerosene, Coal, Wood		
		Mortgage/2nd Mortgage					Telephone		
		Sales/Local Property Tax/ Assessments					Utility Installation Fees		
		Homeowner's Insurance					Unoccupied Home Expenses		
		Water					Car Payment (If car is used as a home)		
		Garbage, Sewer, Trash Collection					Car Insurance (If car is used as a home)		
		Electricity					Other (Specify)		

LIST YOUR LANDLORD'S NAME, ADDRESS AND PHONE NUMBER

29. Are you billed separately for utility cost? ☐ Yes ☐ No If Yes, (✓) check the utilities:
☐ Electric/Gas ☐ Water ☐ Sewer/Trash

If yes, choose one of the following options **"A" or "B"** for each utility billed separately:

Electricity/Gas_____ Water _____ Sewer/Trash _____

A. Standard Utility Allowance (SUA)
The SUA is an amount which reflects the average statewide amount spent for specific utilities and other mandatory fees. You may choose to have either the actual cost or the SUA for each utility cost used in determining the SNAP shelter cost deduction amount.

B. Actual Utility Costs
If you Choose to use ACTUAL COSTS, you will need to verify these costs.

ANY QUESTIONS REGARDING THESE OPTIONS CAN BE DISCUSSED WITH YOUR WORKER. ONCE YOU SELECT AN OPTION, YOU CAN CHANGE IT ONLY ONE TIME IN 12 MONTHS.

30. Does your room or rent payment include meals? ☐ Yes ☐ No If Yes, complete the following:

PAYMENT ROOM/MEALS	NO. OF MEALS PROVIDED PER DAY	MONTHLY AMOUNT
$		$

ALIMONY/CHILD SUPPORT EXPENSES

31. Does anyone pay alimony, child support, or make payments for those whom you claim as tax dependents and do not live in your home? ☐ Yes ☐ No If Yes, complete the following:

TYPE OF PAYMENT	AMOUNT	HOW OFTEN PAID	NAME OF PERSON PAID
	$		
	$		

DEPENDENT CARE EXPENSES

32. Does anyone pay or is anyone billed for the care of a child or disabled adult so someone can work, attend school or training, or look for work? ☐ Yes ☐ No If Yes, complete the following:

NAME OF PERSON RECEIVING CARE	NAME OF PERSON PAYING CARE	BILLING		NAME AND ADDRESS OF PERSON PROVIDING CARE
		YOUR SHARE MONTHLY	TOTAL DUE MONTHLY	

MEDICAL EXPENSES

33. MEDICAL EXPENSES. List current medical bills and estimate for anticipated medical expenses for the next 12 months for members of your household who are: (1) age 60 or older, (2) receiving Supplemental Security Income (SSI), Social Security Disability or Blindness payments, Railroad Retirement or other government disability payments, (3) entitled to, but not receiving SSI or Social Security Disability or Blindness Benefits, (4) a disabled veteran, or (5) a disabled spouse or a child of a deceased Veteran. Medical bills/expenses include Medicare premiums, health and hospitalization insurance premiums, prescription drugs, doctor and dental bills, medical transportation costs, glasses, dentures, hearing aids, service of a nurse, or attendant, etc.

NAME OF PERSON THE EXPENSE IS FOR	ACTUAL AMT. BILLED	ESTIMATED EXPENSE	HOW OFTEN BILLED (MONTHLY, WEEKLY)	NAME OF DOCTOR, HOSPITAL PHARMACY, INSURANCE COMPANY
	$	$		
	$	$		
	$	$		
	$	$		
	$	$		
	$	$		
	$	$		

(1) SOCIAL SECURITY NUMBER(SSN):
Pursuant to 42 USC 1320b-7, the SSNs of persons applying for and receiving help in the Financial and SNAP will be used to check identities of household members prevent duplicate participation, verify income/asset amounts and to do mass changes. SSNs will also be used in program reviews or audits and in computer matching with the Internal Revenue Service, State Department of Labor, and Social Security Administration to make sure your household is eligible. This may result in criminal or civil action of administrative claims against persons fraudulently participating in the Financial Program and SNAP.

(2) YOU HAVE THE RIGHT:
- **To discuss any action** regarding your case with your worker or the supervisor if you are dissatisfied.
- **To be notified in advance** before your benefits are reduced or discontinued.
- To ask for a hearing in writing, or orally for SNAP, if you are dissatisfied with any action by the DHS, and to ask the Legal Aid Society of Hawaii, or anyone you want, to help get a hearing. Your case may be presented at the hearing by any person you choose.
- **To have your record kept confidential.**
- **To have a bilingual or sign-language interpreter.** All our oral and written communication to you will be in English. If you do not understand what you hear or read, please contact your worker right away.
- In accordance with Federal law and U.S. Department of Agriculture (USDA) and U.S. Department of Health and Human Services (HHS) policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. Under the Food and Nutrition Act and USDA policy, discrimination is prohibited also on the basis of religion or political beliefs. To file a complaint of discrimination with the Department, contact the Civil Rights Compliance office at 1390 Miller Street Room 214, or call (808) 586-4955, or contact USDA or HHS Write USDA, Director, Office of Civil Rights, Room 326-W, Whitten Building, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410 or call (202) 720-5964 (voice and TDD). Write HHS, Director, Office for Civil Rights, Room 506-F, 200 Independence Avenue, SW., Washington, D.C. 20201 or call (202) 614-0403 (voice) or (202) 619-3257 (TDD). USDA and HHS are equal opportunity providers and employers.

(3) YOUR RESPONSIBILITIES:
All households (Simplified and Change Reporting) must apply for and accept all potential sources of income and assets. Failure to do so may result in benefits stopping and ineligibility.

SIMPLIFIED REPORTING HOUSEHOLDS

If your household is determined to be a Simplified Reporting household you are required to complete a Six Month Report form. You are only required to report the following items on your Six Month Report: any change in residence; new employment; earned income verification and self-employment expenses all other sources of income; changes in household composition; and any changes in resources. For the SNAP, you must also report a change in shelter cost if you have moved and any changes in legal obligation to pay child support. For the medical program, you must also report changes in private health insurance, the offer of health insurance by an employer, and the occurrence of any accident.
In addition to the Six Month Report, you will have to report the following within 10 days of the change for the financial assistance programs: any change in household composition and when the household's total gross income exceeds 100% of the Federal Poverty Limit (FPL). For the SNAP, you will only be required to report when the household's total gross income exceeds 130% of the FPL. For SNAP households that include a member who is considered an able-bodied adult without dependents (ABAWD), you must report when work or training hours decrease below 20 hours a week or termination of employment or training. Households receiving assistance from more than one program shall report the changes as required for each program. Changes may be reported in writing, in person or by telephone.

REPORTING CHANGES FOR ALL OTHER HOUSEHOLDS

Households who are not simplified reporting households shall be required to report the following changes within ten days of the date the change becomes known; or if the change involves income, the change must be reported within ten days of the date that the first payment is received.
- Unearned Income: A change in the source of unearned income and a change of more than $50 in the amount of unearned income, except changes related to the financial assistance grant. Examples of unearned income: Supplemental Security Income (SSI); Unemployment Compensation (UIB); Veteran's Benefits (VA); Tax Refunds; Insurance Settlements; Inheritance, gifts or contributions from relatives; dividends pensions, retirement or Social Security benefits, child support and alimony, etc.
- Earned Income: All changes in earned income, including starting, stopping or changing a job. Receipt of irregular earned income, for example, commissions, lumpsum payments, etc.
- Household Composition: All changes in household composition, such as the addition or loss of a household member.
- Assets: When cash on hand, stocks, bonds, and money in a bank account or savings institution reaches or exceeds the program's asset limit.
- Changes in Residence and Shelter Costs: A change in residence, and for the SNAP the resulting change in shelter costs.
- Child Support Obligations: For the SNAP, any change in legal obligation to pay child support.

ELECTRONIC BENEFITS TRANSFER (EBT) You are responsible to report lost, stolen, or misused EBT CARDS immediately by calling the EBT toll-free customer service number, or by accessing the EBT website at www.ebtaccount.JPMorgan.com. There will be no replacement of any benefits accessed with an EBT card prior to the card being reported lost, stolen or misused. You are responsible to report immediately any changes in the status of your alternate payee. There will be no replacement of any benefits accessed by alternate payees or any other individuals using an EBT card and a valid PIN. Benefits not withdrawn for 90 days for cash assistance accounts and for 365 days for SNAP accounts will be returned to the state.

(4) PENALTY WARNING:
- **Do not make any false statements or hide any information.**
  Sanctions and court prosecution may be pursued under applicable state and federal laws.
- **Do not do anything dishonest to get money and SNAP benefits which you are not supposed to get.**
- **Do not give or sell your SNAP benefits or EBT card to anyone else.**
- **Do not alter or use someone else's SNAP or EBT card for your household.**
- **Do not use your SNAP benefits or EBT card to buy ineligible items such as alcoholic drinks and tobacco.**
- **For the financial assistance program, an intentional program violation disqualification penalty is twelve months for the first violation, twenty-four months for the second violation and permanently for the third or more violations.**
- **For the SNAP, any household or family member who intentionally breaks SNAP rules, can be fined up to $250,000, imprisoned up to 20 years or both. A member of your household can be barred from SNAP for one year for the first violation; two years for a second violation and permanently for the third or any subsequent violation and an additional 18 months if court ordered. The individual may also be subject to further prosecution under other applicable Federal laws. A member convicted of using or receiving SNAP benefits in a transaction involving the sale of firearms, ammunition or explosives is permanently ineligible to participate in SNAP. Individuals convicted of trafficking SNAP benefits of $500 or more are permanently ineligible.**

Individuals found guilty to have used or received SNAP benefits in a transaction involving the sale of controlled substance are ineligible to participate for two years for first violation and permanently for the second violation. Individuals who have committed and been convicted of Federal or State felonies after 8/22/96 for possession, use or distribution of illegal drugs and who refused to comply with treatment or with a treatment program are ineligible for the program. An individual is ineligible to participate in the financial and SNAP for 10 years if found to have filed more than one application at the same time and have given false identification or residence information. Fleeing felons and probation/parole violators are ineligible for the financial and SNAP.

(5) YOUR AUTHORIZATION:

- I agree that the information I provide to the Department will be subject to verification by Federal, State and local officials to determine if such information is factual; and if any information is incorrect, SNAP benefits may be denied; and I may be subject to criminal prosecution for knowingly providing incorrect information.
- I authorize the Department to check with any financial institution, including, but not limited to, banks, savings and loan associations, thrift companies and credit unions, to verify that I am eligible for help. I authorize any financial institution to provide the Department information, including information on the existence and nature of and amount in any account I may have with the financial institution.
- I agree to provide the necessary documents to verify the statements I have made. If documents are not available, I agree to give the name of person or organization (such as doctor, employer, State or Federal agency) whom the Department may contact for information about me which may be needed to show that I am eligible for help.
- I agree to cooperate with the Department, Federal Quality Control reviewers and/or auditors if my case is selected for a review.
- I understand that the Department may need to release information about me for purposes connected with the administration of the Department's assistance program, or the administration of federally assisted programs which provides assistance on the basis of need.
- I understand that the Department will obtain and exchange information about me to verify my income and eligibility from the Internal Revenue Service and exchange information about me with the Social Security Administration, Department of Labor for wages and Unemployment Compensation, and agencies in all states administering the Income Eligibility Verification System.
- I understand that if SNAP benefits are issued before a determination of financial eligibility is made, that the amount of SNAP benefits may be reduced without further notice as long as I am notified of this possibility on the notice approving SNAP benefits.
- I understand that my residence and business address may be released to law enforcement officers if needed for an official administrative, civil, or criminal law enforcement purpose, or to identify a recipient as a fugitive felon or a parole violator.
- I understand that if my EBT account becomes inactive because I failed to access my benefits, the balance in my EBT account may be used to offset any outstanding overpayments that my household owes the Department.

(6) ASSIGNMENTS AND AGREEMENT:

- **ASSIGNMENT OF RIGHTS:** I understand that as a condition of eligibility for financial assistance, I am assigning to the State of Hawaii any rights to child and spousal support that I may have from another person, for myself or any person for whom I am applying or receiving assistance. This assignment includes rights to support from previous as well as present and future support. Such payments will be used to reimburse the State up to the amount of assistance granted. You may be exempt from this requirement if you fear physical or mental harm to yourself or your children. As a condition of eligibility for financial assistance I understand that by applying, I am assigning to the State of Hawaii my rights to any third party payments for medical care. I will cooperate in obtaining third party payments. I also understand that when I assign child and spousal support to the State I must have the State's permission to negotiate or seek a new court order or otherwise change the existing status of my child or spousal support agreement. I agree to cooperate with the State in establishing paternity for the minor children in my application.
- **REAL PROPERTY AGREEMENT:** I give the Department permission to verify information on my property. I also agree to report to the Department within five days any money received from the sale, lease, exchange or transfer of such property. If I assign or transfer any property for less money than what I get in the open market, my dependents and I will become ineligible for further assistance.

(7) SNAP PRIVACY ACT STATEMENT:

Collection of information for this application, including the social security number (SSN) of each household member is authorized under the Food and Nutrition Act of 2008, as amended, 7 U.S.C. 2011-2036.

- The information will be used to determine whether your household is eligible or continues to be eligible to participate in the SNAP.
- Information may be disclosed to other Federal and State agencies for official examination, and to law enforcement officials for the purpose of apprehending persons fleeing to avoid the law.
- If a SNAP claim arises against your household, the information on the application, including all SSNs, may be referred to Federal and State agencies, as well as to private claims collections agencies for claims collection action.
- The providing of the requested information, including the SSN of each household member, is voluntary. However, failure to provide this information will result in the denial of SNAP benefits to your household.

(8) YOUR CERTIFICATION (MUST BE SIGNED TO BE CONSIDERED A VALID APPLICATION):

Before signing this application, go back and check that you have answered each question. Make sure you understand your rights and responsibilities, the penalty warning, your authorization, your consent, your assignments and agreements.

- I certify under penalty of perjury, that my answers are correct and complete to the best of my knowledge.
- I understand the questions on this application and the penalty for hiding or giving false information.
- I certify that I have been informed of my rights and responsibilities by the worker and I agree to heed these responsibilities.
- I understand the assignments and agreements and agree to fulfill them as a condition of eligibility.

SIGNATURE (OR MARK) OF APPLICANT	DATE	SIGNATURE (OR MARK) OF SPOUSE OR OTHER ADULT APPLICANT (Required for money assistance only)	DATE	WITNESS IF SIGNATURE IS "X"

(9) CERTIFICATION BY AUTHORIZED REPRESENTATIVE ☐ OR OTHER PERSON ASSISTING IN FILLING OUT APPLICATION ☐ : (Please check off one box.)

I helped the applicant fill out this form. I understand that anyone helping another person in dishonestly getting benefits is subject to criminal penalties.
I certify that the answers given by me on this form ☐ is what I know personally about him/her; or ☐ was provided by the applicant/recipient.

SIGNATURE	RELATIONSHIP	DATE

HOME ADDRESS	PHONE NO.

(10) IN CASE OF EMERGENCY OR DEATH, THE PERSON TO CONTACT IS: (Please Print)

NAME	RELATIONSHIP	PHONE NO.	ADDRESS

(11) CERTIFICATION BY ELIGIBILITY WORKER:

I certify that the applicant/recipient has been informed of his/her rights and responsibilities and the possibility of criminal charges for misrepresenting or concealing facts which determine eligibility.

PRINT ELIGIBILITY WORKER'S NAME	SIGNATURE OF ELIGIBILITY WORKER	DATE

State of Hawaii
Department of Human Services

Med-QUEST Division

Medical Assistance Application

Date Received by DHS	**OFFICIAL USE ONLY** Organization Assisting with Application	Case Name Case Number Worker's Name Section/Unit/EW Code ☐ FS/HQ Combo ☐ Medical Only ☐ Upfront AF/GA

1. Please tell us who you are and where you live. This person will receive all mail and phone calls. Also write your name and information in number 3A.

Last Name	First Name	Middle Initial	Best Phone Number to Call	Email Address
Address (Where you live)		Apartment Number	City, State, and Zip Code	
Mailing Address (If it is different from where you live)			What Language Do You Speak Best? *(We will get you a FREE interpreter—see page 7.)*	

2. Please check YES or NO in the boxes below. If you check YES, please complete.

YES	NO		
☐	☐	**A.**	**Is anyone who wants medical assistance pregnant?** *(Unborn children may be counted in the pregnant woman's household size.)* Name_____ Due Date_____ Number of children expected_____
☐	☐	**B.**	**Was the pregnancy confirmed by a home pregnancy test or health care provider?** *(If the answer is NO, we will request verification.)*
☐	☐	**C.**	**Is anyone who wants medical assistance 18-20 years old and claimed as a tax dependent?** *(The tax dependent's parents' or legal guardians' income is counted for the QUEST program.)* Name_____
☐	☐	**D.**	**Is anyone self employed?** *(You may get business expenses deducted.)* Name_____
☐	☐	**E.**	**Is anyone who wants medical assistance in a medical institution or applying for long-term care placement, home and community-based services, DD/MR, or PACE?** *(Program names are listed on page 8. You may be asked to provide more information about assets you owned.)* Name_____ Nursing Home Name_____ Placement Date_____
☐	☐	**F.**	**Is anyone who wants medical assistance 0-18 years old and has an absent or deceased parent?** *(You may be asked to complete more forms.)* Name_____
☐	☐	**G.**	**Is anyone blind, disabled, or 65 years old or older?** *(You may receive income deductions and help with unpaid medical bills.)* Name_____

3. Please tell us about yourself and who lives in your household. List yourself first and use legal names. Write only family members who are responsible for each other, such as spouses, children under 19 years old, and the children's parents. Attach another paper if there are more than 8 persons.

- We need a social security number and citizenship information for each person who wants medical assistance.
- We do not need a social security number and citizenship information if a person does not want medical assistance (non-applicant). However, we may ask for more information if a social security number is not provided.

A. **Last Name**_____
First Name_____
Middle Initial_____
Date of Birth Month____ / Day____ / Year____
Age_____

Wants Medical Assistance
☐ Yes ☐ No

Sex
☐ Male ☐ Female

Relationship to You
☐ Self ☐ Spouse ☐ Child ☐ Stepchild ☐ Other (specify):_____

Marital Status
☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Citizenship (optional for non-applicants)
☐ U.S. or U.S. National ☐ CFA Individual ☐ Lawful Permanent Resident Entry Date:_____ ☐ Other (specify):_____

Ethnicity (optional)
☐ Caucasian ☐ Chinese ☐ Filipino ☐ Hawaiian ☐ Japanese ☐ Other (specify):_____

SOCIAL SECURITY NUMBER (optional for non-applicants) _____

B. **Last Name**_____
First Name_____
Middle Initial_____
Date of Birth Month____ / Day____ / Year____
Age_____

Wants Medical Assistance
☐ Yes ☐ No

Sex
☐ Male ☐ Female

Relationship to You
☐ Self ☐ Spouse ☐ Child ☐ Stepchild ☐ Other (specify):_____

Marital Status
☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Citizenship (optional for non-applicants)
☐ U.S. or U.S. National ☐ CFA Individual ☐ Lawful Permanent Resident Entry Date:_____ ☐ Other (specify):_____

Ethnicity (optional)
☐ Caucasian ☐ Chinese ☐ Filipino ☐ Hawaiian ☐ Japanese ☐ Other (specify):_____

SOCIAL SECURITY NUMBER (optional for non-applicants) _____

C. **Last Name**_____
First Name_____
Middle Initial_____
Date of Birth Month____ / Day____ / Year____
Age_____

Wants Medical Assistance
☐ Yes ☐ No

Sex
☐ Male ☐ Female

Relationship to You
☐ Self ☐ Spouse ☐ Child ☐ Stepchild ☐ Other (specify):_____

Marital Status
☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Citizenship (optional for non-applicants)
☐ U.S. or U.S. National ☐ CFA Individual ☐ Lawful Permanent Resident Entry Date:_____ ☐ Other (specify):_____

Ethnicity (optional)
☐ Caucasian ☐ Chinese ☐ Filipino ☐ Hawaiian ☐ Japanese ☐ Other (specify):_____

SOCIAL SECURITY NUMBER (optional for non-applicants) _____

D. **Last Name**_____
First Name_____
Middle Initial_____
Date of Birth Month____ / Day____ / Year____
Age_____

Wants Medical Assistance
☐ Yes ☐ No

Sex
☐ Male ☐ Female

Relationship to You
☐ Self ☐ Spouse ☐ Child ☐ Stepchild ☐ Other (specify):_____

Marital Status
☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Citizenship (optional for non-applicants)
☐ U.S. or U.S. National ☐ CFA Individual ☐ Lawful Permanent Resident Entry Date:_____ ☐ Other (specify):_____

Ethnicity (optional)
☐ Caucasian ☐ Chinese ☐ Filipino ☐ Hawaiian ☐ Japanese ☐ Other (specify):_____

SOCIAL SECURITY NUMBER (optional for non-applicants) _____

PLEASE GO TO THE NEXT PAGE AND ANSWER ALL QUESTIONS

E. **Last Name**_____
First Name_____
Middle Initial_____
Month Day Year
Date of Birth____/____/____
Age_____

Wants Medical Assistance
☐ Yes
☐ No

Sex
☐ Male
☐ Female

Relationship to You
☐ Self
☐ Spouse
☐ Child
☐ Stepchild
☐ Other (specify):
_____

Marital Status
☐ Single
☐ Married
☐ Separated
☐ Divorced
☐ Widowed

Citizenship (optional for non-applicants)
☐ U.S. or U.S. National
☐ CFA Individual
☐ Lawful Permanent Resident
Entry Date:_____
☐ Other (specify):
_____

Ethnicity (optional)
☐ Caucasian
☐ Chinese
☐ Filipino
☐ Hawaiian
☐ Japanese
☐ Other (specify):
_____

SOCIAL SECURITY NUMBER (optional for non-applicants) _____

F. **Last Name**_____
First Name_____
Middle Initial_____
Month Day Year
Date of Birth____/____/____
Age_____

Wants Medical Assistance
☐ Yes
☐ No

Sex
☐ Male
☐ Female

Relationship to You
☐ Self
☐ Spouse
☐ Child
☐ Stepchild
☐ Other (specify):
_____

Marital Status
☐ Single
☐ Married
☐ Separated
☐ Divorced
☐ Widowed

Citizenship (optional for non-applicants)
☐ U.S. or U.S. National
☐ CFA Individual
☐ Lawful Permanent Resident
Entry Date:_____
☐ Other (specify):
_____

Ethnicity (optional)
☐ Caucasian
☐ Chinese
☐ Filipino
☐ Hawaiian
☐ Japanese
☐ Other (specify):
_____

SOCIAL SECURITY NUMBER (optional for non-applicants) _____

G. **Last Name**_____
First Name_____
Middle Initial_____
Month Day Year
Date of Birth____/____/____
Age_____

Wants Medical Assistance
☐ Yes
☐ No

Sex
☐ Male
☐ Female

Relationship to You
☐ Self
☐ Spouse
☐ Child
☐ Stepchild
☐ Other (specify):
_____

Marital Status
☐ Single
☐ Married
☐ Separated
☐ Divorced
☐ Widowed

Citizenship (optional for non-applicants)
☐ U.S. or U.S. National
☐ CFA Individual
☐ Lawful Permanent Resident
Entry Date:_____
☐ Other (specify):
_____

Ethnicity (optional)
☐ Caucasian
☐ Chinese
☐ Filipino
☐ Hawaiian
☐ Japanese
☐ Other (specify):
_____

SOCIAL SECURITY NUMBER (optional for non-applicants) _____

H. **Last Name**_____
First Name_____
Middle Initial_____
Month Day Year
Date of Birth____/____/____
Age_____

Wants Medical Assistance
☐ Yes
☐ No

Sex
☐ Male
☐ Female

Relationship to You
☐ Self
☐ Spouse
☐ Child
☐ Stepchild
☐ Other (specify):
_____

Marital Status
☐ Single
☐ Married
☐ Separated
☐ Divorced
☐ Widowed

Citizenship (optional for non-applicants)
☐ U.S. or U.S. National
☐ CFA Individual
☐ Lawful Permanent Resident
Entry Date:_____
☐ Other (specify):
_____

Ethnicity (optional)
☐ Caucasian
☐ Chinese
☐ Filipino
☐ Hawaiian
☐ Japanese
☐ Other (specify):
_____

SOCIAL SECURITY NUMBER (optional for non-applicants) _____

4. Please tell us ALL income your household gets each month. If you have no income, complete A and go to number 5.

☐ A. Check here if your household has no income. Tell us how your food, rent, and other living costs are paid:

_____

_____

B. Check YES or NO for **every type** of income listed. If YES, please write information in the boxes and **attach document copies**. Write the person's name and monthly gross amount **(before taxes and deductions—not take home pay)**. Completing this information will help us process your application faster.

YES	NO	Household Income	Person Receiving Income	Monthly Gross Amount
☐	☐	Job: Employer's Name		Total for **Whole Month**
		1.	1.	1. $
		2.	2.	2. $
		3.	3.	3. $
☐	☐	Self-Employment Income		$
☐	☐	Social Security Benefits		$
☐	☐	Supplemental Security Income (SSI)		$
☐	☐	Pension/Retirement Income (write who pays you: _____)		$
☐	☐	Veteran's Benefits		$
☐	☐	Temporary Disability Insurance (TDI) (write who pays you: _____)		$
☐	☐	Worker's Compensation		$
☐	☐	Unemployment Insurance Benefits (UIB)		$
☐	☐	Insurance Settlements (write who pays you: _____)		$
☐	☐	School Grants and Scholarships (write type and dates: _____)		$
☐	☐	Child Support		$
☐	☐	Alimony		$
☐	☐	Child's Income		$
☐	☐	Other Income (please tell us):		$

5. YES ☐ NO ☐ **Does anyone pay for childcare? If YES, please write information in the boxes.** *(You may be allowed these deductions.)*

Person Who Pays	Monthly Cost	Name of Child	Person Providing Care
	$		
	$		
	$		

PLEASE GO TO THE NEXT PAGE AND ANSWER ALL QUESTIONS

6. Please list ALL household assets as of the first day of this month.

☐ A. Check here if you are only requesting medical assistance for persons who are 0-18 years old or a pregnant woman and go to number 7.

B. Check YES or NO for **every type** of asset listed. If YES, please write information in the boxes and **attach document copies**. Write the owner's name, bank or company name, and value. Completing this information will help us process your application faster.

YES	NO	Assets	Owner's Name	Bank or Company Name	Dollar Value
☐	☐	Checking Accounts (write all)			$
☐	☐	Savings Accounts (write all)			$
☐	☐	Cash			$
☐	☐	Income Tax Refunds			$
☐	☐	Stocks and Bonds			$
☐	☐	Money Market Accounts, CDs, and Time Certificates			$
☐	☐	IRA, Keogh, and Deferred Compensation			$
☐	☐	Home or Mobile Home			$
☐	☐	Other Houses, Land, and Buildings			$
☐	☐	Burial Plans: Total Number _____			$
☐	☐	Burial Plots: Total Number _____			$
☐	☐	Life Insurance (Surrender Cash Value)			$
☐	☐	Family or Individual Trust Funds			$
☐	☐	Business Equity (Self-Employed)			$
☐	☐	Boats and Trailers			$
☐	☐	Jewelry, Diamonds, Gold, Silver, Etc.			$

7. Please check YES or NO in the boxes below. If YES, please write information in the boxes.

YES NO

☐ ☐ **A. Has anyone who needs medical assistance for long-term care, home and community-based services, DD/MR, or PACE sold, traded, or given away money, property, other resources, or assets in the past 5 years?** *(You may not get help if you disposed of assets for less than fair market value.)*

Items Sold, Traded, etc.	Transaction Date	Reason for Sale, Transfer, etc.	Actual Owed	Actual Value	Amount Received
			$	$	$
			$	$	$

☐ ☐ **B. Does anyone who needs nursing home assistance or the person's spouse have an annuity?**

Owner's Name	Annuity Company and Policy Number	Value
		$
		$

8. Please check YES or NO in the boxes below. If YES, please write information in the boxes.

YES NO

☐ ☐ **A. Does anyone listed in Question 3 have private health, dental insurance, vision insurance, long-term care insurance, Medicare, TRICARE, VA benefits, or prescription drug coverage?** *(Other insurance may help pay medical, dental, vision, or drug bills.)*

Person Covered	Insurance Name, Type, and Policy Number	Start Month/Year	Premium Amount
			$
			$

☐ ☐ **B. Has an employer offered health insurance to anyone who is employed?** *(We need to know about employer-sponsored health insurance for the employee only **not** his or her children or spouse.)*

Person Covered	Insurance Name, Type, and Policy Number	Start Month/Year	Employer's Name

☐ ☐ **C. Did anyone lose employer-provided health insurance or extended health care coverage (COBRA) in the past 45 days?**

Person's Name	Last Day Covered

☐ ☐ **D. Has anyone been hospitalized or gone to an emergency room in the past 5 days?** *(We may be able to help pay the bills.)*

Person's Name	Service Dates	Provider (Doctor, Hospital, etc.)

☐ ☐ **E. Does anyone who is blind, disabled, or 65 years old or older have unpaid medical bills the past 3 months?** *(We may be able to help pay the bills.)*

Person's Name	Service Dates	Provider (Doctor, Hospital, etc.)

☐ ☐ **F. Does anyone have medical problems or need medical treatment due to an accident or incident?** *(The responsible party may help pay medical bills.)*

Person's Name	Accident or Incident Dates	Provider (Doctor, Hospital, etc.)

☐ ☐ **G. Does anyone need ongoing medical treatment—doctor visits, prescriptions, etc.?** *(We may be able to help pay the bills.)*

Person's Name	Expected Monthly Cost	Provider (Doctor, Hospital, etc.)

9. Please tell us that you read or had read to you the statement below by signing your name and writing the date.

I certify the information I have provided on this application is true to the best of my knowledge. If I intentionally make false statements on this application, I may be prosecuted under Hawaii Revised Statutes §710-1063. I give permission to the State of Hawaii to check my statements. I have read or had read to me the list of rights and responsibilities on page 11 that I may keep for my information.

Applicant's Signature_____ Date_____

10. Certification by Person Assisting the Applicant in Completing this Application

I helped the applicant complete this application or I am applying for an individual who is unable to act on his/her own behalf. I understand that anyone helping an individual to receive benefits dishonestly is subject to criminal penalties. I certify that the answers on this form ☐ were provided by the applicant/recipient or ☐ are what I personally know about him or her.

Representative's Name (Print)_____ Signature_____ Relationship_____ Telephone Number_____ Date_____

[OFFICIAL USE ONLY: MQD EW NAME (Print)_____ SIGNATURE_____ APPLICATION REVIEW DATE_____]

Bilingual and Sign Interpreter Services

☐	Med-QUEST will provide a free bilingual or sign language interpreter. Yes, I need a _____ language interpreter.	English
☐	Med-QUEST 將會供給您一位免費的雙語翻譯員或手勢語的翻譯員。 是，我要一位 (選一個) ☐普通話 / 國語 (M) ☐廣東話 (C) 的翻譯員。	Chinese
☐	Med-QUEST epwe aora emon chon affou ese kamo, mei sinenap non poraus are pomwen poraus. U, U-mochen emon chon affou non kapasen chuuk.	Chuukese
☐	E kōkua a hāʻawi ana ʻo Med-QUEST i kekahi kanaka unuhi ʻōlelo a i ʻole i kekahi kanaka “sign language.” ʻAe, makemake au i kekahi kanaka unuhi ʻōlelo.	Hawaiian
☐	Ti Med-QUEST mangted iti libre nga interprete nga makaammo iti nadumaduma a pagsasao (bilingual) wenno pagsasao babaen iti senyal (sign). Wen, masapul ko ti interprete nga Ilokano.	Ilocano
☐	クエストが、無料で、バイリンガルあるいは手話の通訳をつけてくれます。 はい、私は日本語の通訳が必要です。	Japanese
☐	Med-QUEST 에서는 통역이나 수화 통역사를 무료로 제공 합니다. 네, 저는 한국 통역이 필요 합니다.	Korean
☐	Med-QUEST ຈະຈັດຫາ ນາຍພາສາ ທີ່ເວົ້າໄດ້ສອງພາສາ ຫລື ນາຍພາສາມືກ ໃຫ້ຟຣີ. ແມ່ນແລ້ວ, ຂ້າພະເຈົ້າ ຕ້ອງການ ນາຍພາສາລາວ.	Laotian
☐	Med-QUEST enaj lewōj ejelok wōnen juōn rukok ak rukok kin sign. Aet, iaikuj i juōn rukok kajin majōl.	Marshallese
☐	Med-QUEST pahn kahk sawasikida sewesepehn tohn kawehwei ni sohte pweipwei. Ehi, ih anahne tohn kawehwei ohng ni lokoiahn Pohnpeian.	Pohnpeian
☐	O le a saunia ele Med-QUEST se faamatala upu ile gagana poo le faaaogaina o saini ma lima e aunoa mase totogi. Ioe, oute manaomia se faamatala upu ile gagana Samoa.	Samoan
☐	Med-QUEST le proporcionará un intérprete sin cargo bilingüe o de lenguaje de signos. Sí, necesito un intérprete de español.	Spanish
☐	Ang Med-QUEST ay nagbibigay ng libreng interprete na makakaalam ng iba-ibang wika (bilingual) o lenggwahe sa pamamagitan ng senyas (sign). Oo, kailangan ko ang interprete na Tagalog.	Tagalog
☐	ʻE lava heʻe Med-QUEST ʻo ʻomai e kau fakatonulea ʻo tatau pe kihe lea moe fakaʻilonga lea ʻaki e nima. ʻIo ʻoku ou fiemaʻu e fakatonulea.	Tongan
☐	Med-QUEST sẽ cung cấp một thông dịch viên song ngữ hoặc thông dịch viên ra dấu miễn phí. Vâng, tôi cần một thông dịch viên tiếng Viêt Nam.	Vietnamese

General Questions and Answers

How long does it take for my application to be processed?
Med-QUEST has up to 45 days from the date it receives your application to approve or deny it. However, if the person who needs medical assistance is blind or disabled, they have 90 days to review it. Pregnant women applications are processed within 5 business days if all questions on the application are completed.

What is the difference between QUEST and Fee-for-Service?
Med-QUEST pays health plans for customers enrolled in QUEST, QUEST-ACE, QUEST-Net, and QUEST Expanded Access (QExA). It pays health care providers for customers not enrolled in a health plan.

If I have Medicare, can I still get Medicaid?
Yes. If you qualify for Medicaid, the state may pay your Medicare premiums.

If I have Medicare, will QUEST Expanded Access (QExA) pay for my prescription drugs?
Some drugs not covered by Medicare may be paid by QUEST Expanded Access (QExA).

Do I enroll in a health plan if my application is approved for the QUEST program?
Yes. If you receive a letter from Med-QUEST that your application is approved for QUEST, you must enroll in a health plan within 10 days. You can choose from several health plans by calling our Customer Service Section at 524-3370 (Oahu) or 1-800-316-8005 (Neighbor Islands). You can also fax your request to 692-7224 (Oahu) or 1-800-576-5504 (Neighbor Islands).

Must I live in Hawaii to apply?
Yes. You must be a Hawaii resident. People who need medical assistance must also plan to live in Hawaii indefinitely.

Can only United States citizens get medical assistance?
No. You can be a United States citizen, United States National, lawful permanent resident, qualified alien, or citizen from the Federated States of Micronesia, Republic of the Marshall Islands, or Republic of Palau.

Will enrolling in QUEST or Fee-for-Service affect my immigration status?
No. It will not affect your immigration status. Call the national U.S. Citizenship and Immigration Services center at 1-800-375-5283 for details.

What are the DD/MR and PACE programs?
These programs are Developmental Disabilities/Mental Retardation (DD/MR) and Program of All Inclusive Care for Elderly (PACE). They provide support services so a person can remain at home or live in a community-based setting.

Important Resources

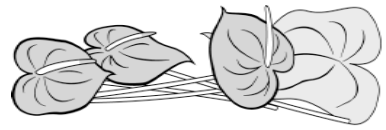
211
Information and referral hotline service sponsored by Aloha United Way. Free call from all islands by dialing 211.

Domestic Violence Legal Hotline
Provides civil legal assistance and advocacy to domestic abuse victims. 531-3771 (Oahu) or www.stoptheviolence.org

Medicare
Information provided by the Centers for Medicare & Medicaid Services.
1-800-633-4227 or www.medicare.gov

Sage PLUS
Provides statewide health insurance information counseling and referrals to people 60 years or older. 586-7299 (Oahu) or 1-888-875-9229 (Neighbor Islands) or www4.hawaii.gov/eoa/programs/sage_plus/

Executive Office on Aging
Dedicated to the well-being of older adults and their caregivers.
586-0100 (Oahu), 974-2400 (Hawaii), 274-3141 (Kauai), 984-2400 (Maui), 1-800-468-4644 (Molokai), or www4.hawaii.gov/eoa/



Common Questions and Answers

Pregnant Women

How long does it take for my application to be processed?
Med-QUEST will process your application within 5 business days if you answer all questions on the application.

What should I do after the baby is born?
Call your Med-QUEST worker and let her or him know the baby's full name and date of birth. If Med-QUEST needs more information, they will contact you. The baby will stay in the mother's health plan for 30 days.

How long will my medical assistance continue?
You will be covered for 60 days after the baby is born. To continue longer, complete Form 1100 to find out if you are eligible as a non-pregnant adult.

If I am not eligible for Med-QUEST's programs, can I apply for my baby?
Yes. If your baby is eligible, benefits begin on the date Med-QUEST receives the application. Also, if you want your birth expenses covered, Med-QUEST must receive your application within 5 calendar days of the baby's delivery. It would be helpful to complete the application before you go to the hospital, take it with you, and ask the hospital staff to fax it to your local Med-QUEST office.

Children

How long does it take for my application to be processed?
Med-QUEST has up to 45 days from the date it gets your application to approve or deny it. However, if the person who needs medical assistance is blind or disabled, they have 90 days to review it.

How soon can my child get health care?
If the application is approved, benefits begin on the date Med-QUEST received the application.

If my child gets sick before the application is approved, what should I do?
Please call a doctor! Private physicians and community health centers can help you. Tell them you have an application pending with Med-QUEST. If you cannot get help because you don't have health insurance, call your local Med-QUEST office and ask for an emergency processing form (1149). Telephone numbers are listed on the last page of the application. You can also download the form at www.coveringkids.com/library/. After the doctor completes the form, bring it to Med-QUEST and they will review your application.

Will enrolling in a health plan or Fee-for-Service affect my immigration status?
No. It will not affect your child's or family's immigration status. Call the national U.S. Citizenship and Immigration Services center at 1-800-375-5283 for details.

Important Resources

211
Information and referral hotline service sponsored by Aloha United Way. Free call from all islands by dialing 211.

Child Abuse and Neglect
Statewide 24-hour hotline. Call if you think a child is abused or neglected. 832-5300 (Oahu).

WIC
Nutrition program for women, infants, and children. 586-8175 (Oahu) or 1-888-820-6425 (Neighbor Islands).

Head Start
Child development programs that serve children from birth to age 5 years old and their families. www.hawaii.gov/dhs/self-sufficiency / childcare/headstart/

MothersCare Information Line
Operated by Healthy Mothers Healthy Babies Coalition of Hawaii. Links pregnant women to health and community resources. 951-6660 (Oahu), 1-888-951-6661 (Neighbor Islands), or www.hmhb-hawaii.org.

Parent Line
Staffed by professionals specializing in child and adolescent growth and development. 526-1222 (Oahu) or 1-800-816-1222 (Neighbor Islands).

Mikah The Myna Bird has friendly advice…

Regular health check-ups are no Myna matter!

EPSDT provides free **E**arly and **P**eriodic **S**creening, **D**iagnosis, and **T**reatment health services for individuals under 21 years old receiving medical assistance through Med-QUEST's programs.

EPSDT offers:

- complete medical and dental examinations
- hearing, vision, and laboratory tests
- immunizations and tuberculosis skin tests
- assistance with scheduling appointments
- help with arranging transportation

☺ Regular health check-ups can keep you healthy ☺

What is EPSDT?
Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services is a program that provides regular medical and dental check-ups for individuals under 21 years old.

Why should EPSDT concern me?
It is important that children and youth get regular checkups so their doctors find health problems before they become serious.

Who can use this program?
Individuals from birth through 20 years old receiving medical assistance through Med-QUEST's programs.

How can the person get EPSDT services?
Individuals receiving medical assistance get EPSDT services through participating health care providers.

If you need more information, help scheduling an appointment, language interpreter, or transportation assistance, please call 692-8110 (Oahu) or 1-866-836-0957 (free from the Neighbor Islands).

Good health can make all the difference in your life ... and that's no Myna matter!

RIGHTS AND RESPONSIBILITIES

WHAT I HAVE THE RIGHT TO EXPECT FROM THE DEPARTMENT:

RIGHT TO CONFIDENTIALITY: Federal and State laws do not allow the Department to release any information I have provided without my written permission unless it is directly related to managing the medical assistance programs.

NO DISCRIMINATION: I will not be treated differently because of my race, color, age, sex, national origin, physical or mental disability, or religious or political beliefs. If I am not satisfied with the way I am treated, I should write as soon as possible to the Department of Human Services Personnel, Civil Rights Compliance Unit, P.O. Box 339, Honolulu, HI 96809-0339 or the U.S. Department of Health and Human Services, Office of Civil Rights/Region IX, 90 7th Street, Suite 4-100, San Francisco, CA 94103-6705, Attention: Regional Manager. I may also call the US DHHS at 1-800-368-1019 (toll free) or 1-415-437-8311 (TDD). I can get a Discrimination Complaint Form, Consent/Release Form, and joint Nondiscrimination Notices in multiple languages at http://hawaii.gov/dhs in the Civil Rights Corner.

FAIR AND FRIENDLY TREATMENT: The Department will make an eligibility determination based on facts within 45 days from the date the application is received by the Department or within 90 days for someone who is applying for medical assistance based on a disability. I will be given correct information and treated with dignity and courtesy at all times.

BILINGUAL, SIGN INTERPRETER, OR OTHER ACCOMMODATIONS: All Department oral and written communication to me will be in English. If I do not understand what I hear or read, I will contact the Department right away. I can get free help to access medical assistance with sign or foreign language interpreters, large print, taped materials, or accessible parking, etc.

RIGHT TO ADVANCE NOTICE AND ADMINISTRATIVE APPEAL: The Department must tell me before they take any action that affects my benefits by mailing me a notice. If I am not satisfied with any decision made by the Department that will affect me, I have 90 days from the date on which the notice is mailed to me to request an administrative appeal. I may ask the Legal Aid Society of Hawaii, another community agency, or anyone else to assist me.

PRE-EXISTING CONDITIONS: Federal law limits when health insurance will not pay for a pre-existing condition. If I enroll in a group health insurance plan that does not cover pre-existing conditions, I can get credit for the time I received medical assistance. I must ask for a certificate of medical coverage within 24 months after my medical assistance coverage ends.

EPSDT: All persons under age 21 can have free regular health and dental check-ups under the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program. Participating physicians, dentists, clinics, and health centers provide EPSDT check-ups, diagnosis, and treatments. If requested, I may also receive help with scheduling appointments and transportation for these checkups.

WHAT THE DEPARTMENT HAS THE RIGHT TO EXPECT OF ME:

SOCIAL SECURITY NUMBER: I am required to provide Social Security Numbers (SSNs) for all persons applying for medical assistance. (42 USC 1320b-7; 42 CFR 435.910(a)) The SSNs are used to verify the income and assets of those applying for medical assistance to determine if they are eligible. I do not have to provide my SSN if I am not applying for medical assistance or if I am a non-lawful alien applying for emergency medical assistance. If I do not provide my SSN, it will not affect my children's eligibility. My SSN will not be shared with U.S. Citizenship and Immigration Service.

CITIZENSHIP: Those persons applying for assistance in my household are U.S. citizens; lawful permanent residents; refugees; asylees; persons granted cancellation of removal, or paroled in the U.S.; nationals of American Samoa or Swain's Island; Cuban, Haitian, or conditional entrants; Amerasian immigrants; honorably discharged or active duty military, or their spouse or dependent children; battered spouse or children, or children of a battered spouse under the Violence Against Women Act; citizens of the Federated States of Micronesia, Marshall Islands, or Palau, or permanently residing in Hawaii under color of law; or otherwise authorized by law to receive assistance. I must provide proof of lawful immigration status unless I am not applying for medical assistance, or I am an alien that entered the U.S. on or after August 22, 1996 and am applying for emergency medical services. (42 CFR 435.910(a))

COOPERATION AND GOOD CAUSE: Help is available to me through the Child Support Enforcement Agency (CSEA) if I need to obtain medical support for my children. I do not have to cooperate with CSEA if it is not in the best interest of my children. Otherwise, I will help my children get medical support by helping CSEA identify the father(s) of my children. If I do not cooperate because I believe it may not be in the best interest of my household, I must provide information to support this. Without good cause, it will not affect my children's medical assistance, however I will not be eligible for medical assistance unless I am pregnant.

THIRD PARTY LIABILITY: I will give the State of Hawaii any health insurance payments or other money received for medical care for the time anyone in my household receives assistance. If I do not cooperate because I believe it may not be in the best interest of my household, I must provide information to support this. Without good cause, it will not affect my children's medical assistance, however I may not be eligible for medical assistance unless I am pregnant.

ASSETS AND OTHER PROPERTIES: I must give the Department information about any asset or property that is owned by my household unless I am only applying for medical assistance for children or as a pregnant woman. If I get rid of any income, asset or property for less money than the fair market value, it may affect my eligibility for nursing facility level care. An annuity purchased after February 8, 2006 must name the State as a remainder beneficiary.

REPORTING ANY CHANGES: I will report to the Department all changes about my household within 10 days of when I learn of the changes as they may affect my eligibility for medical assistance. Changes to report include, among other things: income; addresses; living arrangement; marriage/divorce; pregnancy; birth; death; insurance coverage. It also includes the injuries from accidents; receipt, transfer or sale of any asset (i.e. home, car, etc.); or receipt of a Social Security Number. I must also report when anyone enters a hospital or public institution, or moves out of the State of Hawaii.

VERIFICATION OF INFORMATION: The Department may contact Federal, State, and local officials to make sure the information that I provide is true. I agree to help the Department, its agents and contractors, and Federal reviewers and/or auditors if my case is reviewed. The Department may call any bank or other financial institution to get information about the accounts that belong to my household.

PENALTY WARNING: All information given by me on all forms is true and complete to the best of my knowledge. If I give wrong information on purpose or have someone give wrong information on purpose to help me get medical assistance coverage, I may have to pay penalties and/or repay any medical assistance I received.

APPLYING FOR MEDICAL ASSISTANCE

Please check to see that you completed all necessary information on the medical assistance application and it is signed and dated. This will help us process it faster. If the application is incomplete, you may be contacted for more information.

You may take your completed medical assistance application to the Med-QUEST eligibility office near where you live or mail it to the address below. You can also fax it to your local office. If you have questions about your application, please call your local eligibility office.

OFFICE ADDRESSES	MAILING ADDRESSES	TELEPHONE AND FACSIMILE NUMBERS
Oahu Section 801 Dillingham Boulevard, 3rd Floor Honolulu, HI 96817-4582	**Oahu Section** P. O. Box 3490 Honolulu, HI 96811-3490	**Phone 587-3521 or 587-3540** **Fax 587-3543**
Kapolei Unit Kakuhihewa State Office Building 601 Kamokila Boulevard, Room 415 Kapolei, HI 96707-2021	**Kapolei Unit** P. O. Box 29920 Honolulu, HI 96820-2320	**Phone 692-7364** **Fax 692-7379**
East Hawaii Section 88 Kanoelehua Avenue, Room 107 Hilo, HI 96720-4670	**East Hawaii Section** 88 Kanoelehua Avenue, Room 107 Hilo, HI 96720-4670	**Phone 933-0339** **Fax 933-0344**
West Hawaii Section Lanihau Professional Center 75-5591 Palani Road, Suite 3004 Kailua-Kona, HI 96740-3633	**West Hawaii Section** Lanihau Professional Center 75-5591 Palani Road, Suite 3004 Kailua-Kona, HI 96740-3633	**Phone 327-4970** **Fax 327-4975**
Lanai Unit 730 Lanai Avenue Lanai City, HI 96763	**Lanai Unit** P. O. Box 737 Lanai City, HI 96763-0737	**Phone 565-7102** **Fax 565-6460**
Maui Section Millyard Plaza 210 Imi Kala Street, Suite 101 Wailuku, HI 96793-1274	**Maui Section** Millyard Plaza 210 Imi Kala Street, Suite 101 Wailuku, HI 96793-1274	**Phone 243-5780** **Fax 243-5788**
Molokai Unit State Civic Center 65 Makaena Street, Room 110 Kaunakakai, HI 96748	**Molokai Unit** P. O. Box 1619 Kaunakakai, HI 96748-1619	**Phone 553-1758** **Fax 553-3833**
Kauai Unit 4473 Pahee Street, Suite A Lihue, HI 96766-2037	**Kauai Unit** 4473 Pahee Street, Suite A Lihue, HI 96766-2037	**Phone 241-3575** **Fax 241-3583**