IF YOU WANT TO APPLY FOR:
FINANCIAL, SNAP & MEDICAL ASSISTANCE
FOR SNAP ONLY
FOR QUEST/MEDICAL ONLY

use addresses below
use addresses below
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, Waieke, 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.

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**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

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**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

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**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
**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.

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

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](http://hawaii.gov/dhs/quicklinks/What Is TANF)
APPLICATION FOR FINANCIAL AND SNAP ASSISTANCE

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.

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

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 must be interviewed 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 appointment 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?

☐ 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 _________

Yes  No

☐ 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) _________

☐ Has anyone in your home received financial benefits within two (2) working days and/or SNAP within seven (7) calendar days from the date of application.

☐ Is a seasonal farmworker household whose only source of income for the month terminated before applying, is not expecting income of $25 within the next 10 days and has liquid assets of less than $100.

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

APPLICATION FOR FINANCIAL AND SNAP ASSISTANCE

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.

I would like to apply for the following types of benefits:

______________________________________________________________________________________________________
______________________________________________________________________________________________________
___________________________
This signature is required for Money Assistance only

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 must be interviewed 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:

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YES  NO

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☐ 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 _________

Yes  No

☐ 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) _________

☐ Has anyone in your home received financial benefits within two (2) working days and/or SNAP within seven (7) calendar days from the date of application.

☐ 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.
### 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.

<table>
<thead>
<tr>
<th>Last Name, First, M.I.</th>
<th>SEX</th>
<th>BIRTHDATE</th>
<th>SOCIAL SECURITY NUMBER</th>
<th>NAME OF CHILD’S PARENT(S) IF NOT IN THE HOME</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
<td>(42 USC 1320b-7 requires that SSN’s be provided for each household member applying for assistance.)</td>
</tr>
</tbody>
</table>

#### 1. OTHER NAMES USED

<table>
<thead>
<tr>
<th>Number</th>
<th>AGE</th>
<th></th>
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<tbody>
<tr>
<td>1</td>
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<td>8</td>
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</tbody>
</table>

#### 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.

<table>
<thead>
<tr>
<th>Number</th>
<th>AGE</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>1</td>
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<td>3</td>
<td></td>
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<tr>
<td>4</td>
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</tr>
</tbody>
</table>

#### 3. Is anyone temporarily out of the home?

- [ ] Yes
- [ ] No

<table>
<thead>
<tr>
<th>Name</th>
<th>Date Left</th>
<th>Date to Return</th>
<th>Where Person Went</th>
</tr>
</thead>
</table>

#### (*) Relationship Codes to Person #1:

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

#### (**) Ethnic Codes - Select only one code:

- HI - Hispanic
- NH - Not Hispanic
- WH - White
- BL - Black
- AI - American Indian or Alaskan Native
- HA - Hawaiian
- SA - Samoan
- FC - Foster Child
- EX - Ex-Spouse
- GR - Grandparent
- GC - Grandchild
- NR - Not Related
- OR - Other Related
- UB - Unborn
- SI - Sibling
- AU - Aunt/Uncle
- NN - Niece/Nephew

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

- WH - White
- BL - Black
- AI - American Indian or Alaskan Native
- HA - Hawaiian
- SA - Samoan
- FC - Foster Child

#### (***) 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

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

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REAP ALMA SEPA SSDO ETRC SPRD MAST 2
**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: ________________

**COMPLETE IF YOU ARE A NON-U.S. CITIZEN**

<table>
<thead>
<tr>
<th>Name</th>
<th>US US Nat’l</th>
<th>US Non-US Cit.</th>
<th>Birthplace</th>
<th>Date of Entry</th>
<th>Immigration Status</th>
<th>Effective Date Of Status</th>
<th>INS Form or Alien Registration Number</th>
<th>Do you, your spouse, or parent have 40 qtrs. of work? (Y/N)</th>
<th>Veteran or Active Military? (Y/N)</th>
<th>Spouse or Dep. Child of Veteran or Act. Military? (Y/N)</th>
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<tbody>
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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).

<table>
<thead>
<tr>
<th>Name</th>
<th>Address</th>
<th>Phone</th>
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<tr>
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ADDRE SEPO SSDDO MINDA ETRC 3
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

<table>
<thead>
<tr>
<th>NAME</th>
<th>Type of Assistance</th>
<th>Date Last Received</th>
<th>County/State Last Received</th>
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<tbody>
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</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>NAME</th>
<th>PROGRAM</th>
<th>DISQUALIFICATION PERIOD</th>
<th>COUNTY/STATE</th>
</tr>
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<tbody>
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</table>

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

<table>
<thead>
<tr>
<th>NAME</th>
<th>Job or Training Program</th>
<th>Participation Dates</th>
</tr>
</thead>
<tbody>
<tr>
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</table>

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**

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
<th>ASSETS</th>
<th>NAME OF PERSON(S) ON ACCOUNT</th>
<th>NAME OF FINANCIAL INSTITUTION &amp; BRANCH</th>
<th>ACCOUNT NO.</th>
<th>AMOUNT</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Checking Accounts: Personal/Business</td>
<td></td>
<td></td>
<td></td>
<td>$</td>
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<tr>
<td></td>
<td></td>
<td>Savings Accounts</td>
<td></td>
<td></td>
<td></td>
<td>$</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Credit Union Accounts</td>
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<td></td>
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<td>Christmas Savings</td>
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<td></td>
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<td>Stock/Bonds (savings bonds)</td>
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<td></td>
<td></td>
<td>Money Market/Time Certificate</td>
<td></td>
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<td>IRA/KEOGH Deferred Comp.</td>
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</table>

**LIQUID ASSETS**

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
<th>ASSETS</th>
<th>NAME OF PERSON(S) ON ACCOUNT</th>
<th>NAME OF FINANCIAL INSTITUTION &amp; BRANCH</th>
<th>ACCOUNT NO.</th>
<th>AMOUNT</th>
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</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Cash on Hand</td>
<td></td>
<td></td>
<td></td>
<td>$</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Tax Refund/Tax Credit</td>
<td></td>
<td></td>
<td></td>
<td>$</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Stocks/Bonds</td>
<td></td>
<td></td>
<td></td>
<td>$</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Money Market/Time Certificate</td>
<td></td>
<td></td>
<td></td>
<td>$</td>
</tr>
<tr>
<td></td>
<td></td>
<td>IRA/KEOGH Deferred Comp.</td>
<td></td>
<td></td>
<td></td>
<td>$</td>
</tr>
</tbody>
</table>

**OTHER ASSETS**

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

**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:

<table>
<thead>
<tr>
<th>ITEM SOLD, TRADED, ETC.</th>
<th>DATE</th>
<th>REASON FOR SELLING, TRANSFERING, ETC.</th>
<th>ACTUAL VALUE OF ITEM</th>
<th>AMOUNT OWED</th>
<th>AMOUNT RECEIVED</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>$</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
</tbody>
</table>

**STUDENT INFORMATION**

17. Is anyone aged 16 years and older a student?  

- [ ] Yes
- [ ] No

If yes, complete below:

<table>
<thead>
<tr>
<th>NAME OF STUDENT</th>
<th>NAME OF SCHOOL</th>
<th>FULL TIME?</th>
<th>PART TIME?</th>
<th>START DATE MO./DAY/YR.</th>
<th>END DATE MO./DAY/YR.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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.

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

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

<table>
<thead>
<tr>
<th>Applicant:</th>
<th>1.</th>
<th>2.</th>
<th>3.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spouse:</td>
<td>1.</td>
<td>2.</td>
<td>3.</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>PERSON EMPLOYED</th>
<th>JOB TITLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>EMPLOYER</td>
<td>DATE STARTED</td>
</tr>
<tr>
<td>ADDRESS</td>
<td>PHONE</td>
</tr>
<tr>
<td>HOW OFTEN PAID</td>
<td>PAYDAY</td>
</tr>
<tr>
<td>HOURS WORKED PER WEEK</td>
<td>HOURLY RATE OF PAY</td>
</tr>
<tr>
<td>$</td>
<td>$</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PERSON EMPLOYED</th>
<th>JOB TITLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>EMPLOYER</td>
<td>DATE STARTED</td>
</tr>
<tr>
<td>ADDRESS</td>
<td>PHONE</td>
</tr>
<tr>
<td>HOW OFTEN PAID</td>
<td>PAYDAY</td>
</tr>
<tr>
<td>HOURS WORKED PER WEEK</td>
<td>HOURLY RATE OF PAY</td>
</tr>
<tr>
<td>$</td>
<td>$</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PERSON EMPLOYED</th>
<th>JOB TITLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>EMPLOYER</td>
<td>DATE STARTED</td>
</tr>
<tr>
<td>ADDRESS</td>
<td>PHONE</td>
</tr>
<tr>
<td>HOW OFTEN PAID</td>
<td>PAYDAY</td>
</tr>
<tr>
<td>HOURS WORKED PER WEEK</td>
<td>HOURLY RATE OF PAY</td>
</tr>
<tr>
<td>$</td>
<td>$</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>SELF-EMPLOYED PERSON</th>
<th>TYPE OF BUSINESS</th>
<th>HOURS WORKED PER WEEK</th>
<th>MONTHLY GROSS</th>
<th>MONTHLY EXPENSES</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>$</td>
<td>$</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>ROOMER'S/BOARDER'S NAME</th>
<th>MONTHLY AMOUNT RECEIVED</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>ROOM</td>
</tr>
<tr>
<td></td>
<td>$</td>
</tr>
<tr>
<td></td>
<td>$</td>
</tr>
<tr>
<td></td>
<td>$</td>
</tr>
</tbody>
</table>

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:

<table>
<thead>
<tr>
<th>NAME OF PERSON</th>
<th>EXPLAIN</th>
<th>DATE OF CHANGE</th>
</tr>
</thead>
</table>
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):

<table>
<thead>
<tr>
<th>Item</th>
<th>How Often Billed</th>
<th>Current Billed Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rent</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Boat Slip</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mortgage/2nd Mortgage</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sales/Local Property Tax/Assessments</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Homeowner's Insurance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Water</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Garbage, Sewer, Trash Collection</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Electricity</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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:

<table>
<thead>
<tr>
<th>Item</th>
<th>How Often Billed</th>
<th>Current Billed Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rent</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Boat Slip</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mortgage/2nd Mortgage</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sales/Local Property Tax/Assessments</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Homeowner's Insurance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Water</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Garbage, Sewer, Trash Collection</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Electricity</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

LIST YOUR LANDLORD'S NAME, ADDRESS AND PHONE NUMBER

29. Are you billed separately for utility cost?  
- Yes  
- No  
If Yes, (✓) check the utilities:

<table>
<thead>
<tr>
<th>Utility</th>
<th>How Often Billed</th>
<th>Current Billed Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Electric/Gas</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Water</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sewer/Trash</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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:

<table>
<thead>
<tr>
<th>Payment Room/Meals</th>
<th>No. of Meals Provided Per Day</th>
<th>Monthly Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>$</td>
<td></td>
<td>$</td>
</tr>
</tbody>
</table>
### 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:

<table>
<thead>
<tr>
<th>TYPE OF PAYMENT</th>
<th>AMOUNT</th>
<th>HOW OFTEN PAID</th>
<th>NAME OF PERSON PAID</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>$</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 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:

<table>
<thead>
<tr>
<th>NAME OF PERSON RECEIVING CARE</th>
<th>NAME OF PERSON PAYING CARE</th>
<th>BILLING</th>
<th>NAME AND ADDRESS OF PERSON PROVIDING CARE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>YOUR SHARE MONTHLY</td>
<td>TOTAL DUE MONTHLY</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

### 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,
- (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.

<table>
<thead>
<tr>
<th>NAME OF PERSON THE EXPENSE IS FOR</th>
<th>ACTUAL AMT BILLED</th>
<th>ESTIMATED EXPENSE</th>
<th>HOW OFTEN BILLED (MONTHLY, WEEKLY)</th>
<th>NAME OF DOCTOR, HOSPITAL PHARMACY, INSURANCE COMPANY</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$</td>
<td>$</td>
<td></td>
<td></td>
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<td>$</td>
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<td></td>
</tr>
</tbody>
</table>
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 are told, you can have another person present at the meeting.
- To have your record kept confidential.
- To have another person present at the meeting.
- To have a written or oral statement in advance of the hearing.

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 shelter cost if you have moved and any changes in legal obligation to pay child support. For the SNAP, any change in legal obligation to pay child support. 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 any subsequent 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 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 assigning, 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 authorized under the Food and Nutrition Act of 2008, as amended, 7 U.S.C. 2011-2036.

(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 that my answers are correct and complete to the best of my knowledge.
• I certify that 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.

(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.

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

(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.
<table>
<thead>
<tr>
<th>Question</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Please tell us who you are and where you live. Also write your name and information.</td>
</tr>
<tr>
<td>2.</td>
<td>Please check YES or NO in the boxes below. If you check YES, please complete.</td>
</tr>
</tbody>
</table>

### Personal Information

**Last Name**

**First Name**

**Middle Initial**

**Best Phone Number to Call**

**Email Address**

**City, State, and Zip Code**

**Address (Where you live)**

**Department Name**

**Worker's Name**

**Case Number**

**Case Name**

**Medical Assistance Application**

**FS/HQ Combo**

**Medical Only**

**Section Unit Code**

**Organizational Assistance with Application**

**Date Received by DHS**
### DHS 1100 (Rev. 06/09)

#### 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.

<table>
<thead>
<tr>
<th>A. Last Name</th>
<th>First Name</th>
<th>Middle Initial</th>
<th>Month Day Year Date of Birth</th>
<th>Age</th>
<th>Sex</th>
</tr>
</thead>
<tbody>
<tr>
<td>B. Last Name</td>
<td>First Name</td>
<td>Middle Initial</td>
<td>Month Day Year Date of Birth</td>
<td>Age</td>
<td>Sex</td>
</tr>
<tr>
<td>C. Last Name</td>
<td>First Name</td>
<td>Middle Initial</td>
<td>Month Day Year Date of Birth</td>
<td>Age</td>
<td>Sex</td>
</tr>
<tr>
<td>D. Last Name</td>
<td>First Name</td>
<td>Middle Initial</td>
<td>Month Day Year Date of Birth</td>
<td>Age</td>
<td>Sex</td>
</tr>
</tbody>
</table>

**Relationship to You**
- Self
- Spouse
- Child
- Stepchild
- Other (specify):

**Marital Status**
- Single
- Married
- Separated
- Divorced
- Widowed

**Ethnicity**
- Caucasian
- Chinese
- Filipino
- Hawaiian
- Japanese
- Other (specify):

**Social Security Number** (optional for non-applicants)

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

**Information if a social security number is not provided:**
- 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.
- We need a social security number and citizenship information for each person who wants medical assistance.

For persons under 18 years of age, such as spouses, children under 19 years old, and the children’s parents, attach another paper if there are more than 8 persons.

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.
### Form Section

- **E. Last Name**
- **First Name**
- **Middle Initial**
- **Date of Birth** (Month Day Year)
- **Age**
- **Wants Medical Assistance**
- **Sex**
- **Relationship to You**
- **Marital Status**
- **Social Security Number** (optional for non-applicants)
- **Citizenship** (optional for non-applicants)
- **Ethnicity** (optional)

#### Ethics Information:
- Caucasian
- Chinese
- Filipino
- Hawaiian
- Japanese
- Other (specify):
4. Please tell us ALL income your household gets each month. If you have no income, complete A and go to number 5.

<table>
<thead>
<tr>
<th>Household Income</th>
<th>Person Receiving Income</th>
<th>Monthly Gross Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Job: Employer's Name</td>
<td>Total for Whole Month</td>
<td></td>
</tr>
<tr>
<td>Self-Employment Income</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social Security Benefits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Supplemental Security Income (SSI)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pension/Retirement Income (write who pays you):</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Veteran's Benefits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Temporary Disability Insurance (TDI) (write who pays you):</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Workers' Compensation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>School Grants and Scholarships (write type and dates):</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Insurance Settlements (write who pays you):</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

5. Does anyone pay for childcare? If YES, please write information in the boxes. (You may be allowed these deductions.)

<table>
<thead>
<tr>
<th>Person Who Pays Childcare</th>
<th>Monthly Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Child</td>
<td></td>
</tr>
</tbody>
</table>
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.

- Checking Accounts (write all)
- Savings Accounts (write all)
- Income Tax Refunds
- Business Equity (Self-Employed)
- Family or Individual Trust Funds

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

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

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

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?

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?

Person Covered

Insurance Name, Type, and Policy Number

Start Month/Year

Employer's Name

Person Covered

Insurance Name, Type, and Policy Number

Start Month/Year

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?

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?

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?

Person's Name

Accident or Incident Dates

Provider (Doctor, Hospital, etc.)

G. Does anyone need ongoing medical treatment—doctor visits, prescriptions, etc.?

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 the Application

I helped the applicant complete this application or am applying for an individual who is unable to do so on his or her own behalf. I understand that anyone helping an individual to complete this application is subject to criminal penalties. I certify that the answers on this form were provided by the applicant/recipient or the person applying to receive benefits. I have read or had read to me the list of rights and responsibilities on page 11 that I may keep for my information.

Representative's Name (Print)

Signature

Telephone Number

Date

(We need to know about employer-sponsored health insurance for the employee only, not his or her children or spouse.)
Bilingual and Sign Interpreter Services

Yes, I need a language interpreter.

English

Med-QUEST will provide a free bilingual or sign language interpreter.
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).

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](http://www.stoptheviolence.org)

- **Medicare**
  - Information provided by the Centers for Medicare & Medicaid Services. 1-800-633-4227 or [www.medicare.gov](http://www.medicare.gov)

- **Sage PLUS**
  - Provides statewide health insurance information and counseling services to people 60 years or older. 586-7299 (Oahu) or 1-888-576-5504 (Neighbor Islands) or [www4.hawaii.gov/eoa/programs/sage_plus](http://www4.hawaii.gov/eoa/programs/sage_plus)
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. Health insurance will be set up for the baby. If you have an application pending with Med-QUEST, you can go to the hospital and fill out the application. 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 another application within 5 calendar days of the baby's delivery. If you are not eligible for Med-QUEST, you can apply for your baby through the Children's Health Insurance Program (CHIP).

If I am not eligible for Med-QUEST, can I apply for my baby?
You may apply for your baby through the Children's Health Insurance Program (CHIP) or the Hawaii State Children's Health Insurance Program (HSC program). You must apply within 30 calendar days of the baby's birth to be eligible for assistance.

If my child gets sick before the application is approved, what should I do?
If your child gets sick before the application is approved, receive care and then apply. If your child gets sick after the application is approved, call your Med-QUEST worker and let them know.

Important Resources

- **WIC (Women, Infants, and Children)**: A nutrition program for women, infants, and children. 832-5300 (Oahu) or 1-888-820-6425 (Neighbor Islands).
- **Parent Line**: Staffed by professionals specializing in child development. 800-816-1222 (Neighbor Islands) or 526-1222 (Oahu).
Good health can make all the difference in your life... and that's no Myna matter!

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).

Individuals receiving medical assistance are eligible for EPSDT services through participating health care providers.

How can the person get EPSDT services?

Individuals from birth through 20 years old receiving medical assistance through Med-QUEST's programs.

Why can the person get EPSDT services?

Individuals from birth through 20 years old.

Who can use this program?

Check-ups for individuals under 21 years old.

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 receiving medical assistance through Med-QUEST's programs.

How does EPSDT help you healthier?

EPSDT offers:

- Immunizations and tuberculosis skin tests
- Hearing, vision, and laboratory tests
- Complete medical and dental examinations
- Assistance with scheduling appointments
- Help with arranging transportation assistance

Regular health check-ups can keep you healthy!

Mikah The Myna Bird has friendly advice...

Mikah The Myna Bird

DHS 1100 (Rev. 06/09)
WHAT THE DEPARTMENT HAS THE RIGHT TO EXPECT OF ME:

Social Security Number.

I am required to provide Social Security Numbers (SSNs):

- for each person who is applying for medical assistance.
- for each person who is a member of my household.

The Department may call any bank or other financial institution to get information about the accounts of any person I provide as a Social Security Number. I must also report when anyone enters a hospital or public institution, or is injured from an accident, or has a disease or condition. If I get rid of any income, asset or property for less than its fair market value, for my convenience, or for the convenience of anyone else, I must give the Department information about it. If I enroll in a group health insurance plan that does not cover pre-existing conditions, I must provide information to support this. Without good cause, it will not affect my children's medical eligibility. My SSN will not be shared with U.S. Citizenship and Immigration Service.

Without good cause, it will not affect my children's eligibility. My SSN will not be shared with U.S. Citizenship and Immigration Service. I will not be treated differently because of my race, color, age, sex, national origin, physical or mental disability, marital status, 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 Legal Aid Society of Hawaii, another community agency, or anyone else to assist me. Legal Aid Society of Hawaii, another community agency, or anyone else to assist me.

Rights and Responsibilities

WHAT I HAVE THE RIGHT TO EXPECT FROM THE DEPARTMENT:

I will not receive benefits if I fail to provide Social Security Numbers for all persons applying for medical assistance. (42 USC 1320b-7; 42 CFR 435.910(a)) The SSNs I am required to provide are not for any use other than for eligibility determination, program administration, and/or repayment of medical assistance I received. If I give wrong information to help me get medical assistance coverage, I may have to pay penalties.

WHAT THE DEPARTMENT HAS THE RIGHT TO EXPECT OF ME:

I will cooperate with CSEA if it is not in the best interest of my children. Otherwise, I will help my children get help. I will not be treated differently because of my race, color, age, sex, national origin, physical or mental disability, marital status, 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 Legal Aid Society of Hawaii, another community agency, or anyone else to assist me. Legal Aid Society of Hawaii, another community agency, or anyone else to assist me.

I will cooperate with CSEA if it is not in the best interest of my children. Otherwise, I will help my children get help.

I can get free help to access medical assistance, however I may not be eligible for medical assistance unless I am pregnant.

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. 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 receiving assistance. It also includes the following: income; addresses; living arrangements; marriage/divorce; pregnancy; birth; death; insurance coverage. It also includes the following: income; addresses; living arrangements; marriage/divorce; pregnancy; birth; death; insurance coverage.

I must give the Department information about any injury, transfer of any asset (i.e. home, car, etc.); or receipt of a financial public assistance. Changes to report include, among other things: income; addresses; living arrangements; marriage/divorce; pregnancy; birth; death; insurance coverage. It also includes the following: income; addresses; living arrangements; marriage/divorce; pregnancy; birth; death; insurance coverage.

I can get free help to access medical assistance, however I may not be eligible for medical assistance unless I am pregnant.

I will cooperate with CSEA if it is not in the best interest of my children. Otherwise, I will help my children get help. I do not have to cooperate because I believe it may not be in the best interest of my household, I must tell me before they take any action that affects my benefits by mailing me a notice. If I am not satisfied with the way I am treated, I should write as soon as possible to the Department of Human Rights and Responsibilities.

I will cooperate with CSEA if it is not in the best interest of my children. Otherwise, I will help my children get help. I can get free help to access medical assistance, however I may not be eligible for medical assistance unless I am pregnant. I may ask the Department to provide: Spanish, a sign interpreter, or other accommodations.

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I will cooperate with CSEA if it is not in the best interest of my children. Otherwise, I will help my children get help. I can get free help to access medical assistance, however I may not be eligible for medical assistance unless I am pregnant.
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

<table>
<thead>
<tr>
<th>Office</th>
<th>Mailing Addresses</th>
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</table>
| Oahu Section | 801 Dillingham Boulevard, 3rd Floor  
Honolulu, HI 96817-4582 |
| | Laneli, HI 96811-3490 |
| | Phone 587-3521 or 587-3540  
Fax 587-3543 |
| Kauai Unit | 4473 Pahee Street, Suite A  
Kauai, HI 96766-2037  
Kauai Unit |
| | Phone 241-3575  
Fax 241-3575 |

| Oahu Section | PO Box 3490  
Honolulu, HI 96811-3490 |
| Kapolei Unit | P O Box 29920  
Honolulu, HI 96820-2320 |
| | Phone 692-7364  
Fax 692-7379 |
| | P O Box 73  
Lanai City, HI 96763-0737 |
| Lanai Unit | 730 Lanai Avenue  
Lanai City, HI 96763 |
| | Phone 565-7102  
Fax 565-6460 |
| | 65 Makawao Street, Suite 110  
Maui Civic Center |
| Maui Section | Phone 243-5780  
Fax 243-5788 |
| | 210 Manhattan Street, Suite 101  
Millennium Plaza  
Maui Section |
| West Hawaii Section | 75-5591 Palani Road, Suite 3004  
Kailua-Kona, HI 96740-3633 |
| | 88 Kamehameha Avenue, Room 107  
East Hawaii Section |
| | Phone 327-4970  
Fax 327-4975 |
| | 65 Makaleka Street, Suite 6  
Kapolei, HI 96707-2739 |
| Kauai Unit | 601 Kamokila Boulevard, Room 415  
Kailua-Kona, HI 96740-3633 |
| | Phone 241-3575  
Fax 241-3583 |
| | 801 Dillingham Boulevard, 3rd Floor  
Oahu Section |
| | Phone 578-3540  
Fax 578-3543 |
| | 1050 Niu Valley Road, Room 15  
Kahului, HI 96732-1490 |
| | Phone 808-871-4362  
Fax 808-871-4362 |