

STATE OF HAWAII Department of Human Services Med-QUEST Division ELIGIBILITY DETERMINATION FORM	Worker Name	Sec/Unit	Application Date	
	Case Name		Case Number	
	Interview Date	CS/OV/TC	<input type="checkbox"/> Retro-medical?	<input type="checkbox"/> 8010 sent?
Pregnant Woman Name: _____	Due Date (EDC): _____	Number child(ren) expected: _____	Person Interviewed	Relationship (if applicable)

BASIC ELIGIBILITY REQUIREMENTS – How Verified

HH Member/ Relationship (Specified relative/ Essential person)	(PI)			
Residency				
U.S. Citizen/ U.S. National				
Alien Status/ DOE/Sponsored?				
Photo ID				
DOB				
SSN				
Assets				
Unearned/Earned Income				
Childcare Expense(s)				
TPL(s) Type/ Effective Date/ Policy/Claim #				
Medicare / Effective Date/ Claim #				
Health Plan Premium(s)				

PROGRAM/ Coverage Group				
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DISPOSITION				
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REASON				
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EFF. DATE				
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REV. DATE				
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PRINT NAME OF EW:	SIGNATURE OF EW:	DATE:
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FOLLOW-UP/DATE DUE:

INCURRED MEDICAL EXPENSES (QUEST-SPENDDOWN AND ABD ONLY)

For QUEST-Spenddown, use DHS 1100D. For ABD, use worksheet in H.A.R. procedure section 17-1721-37.				Monthly Spenddown Amount/Enrollment Fee:
Who received service?	Medical Provider(s):	Service Date(s):	Balance of Bill(s):	
			\$	\$
			\$	\$
			\$	\$
			\$	\$

Calculate amount of medical expenses from prior months used to meet monthly spenddown and document on EWAL.

Is the individual or HH willing to pay monthly Enrollment Fee to QExA plan? Yes No If no, deny/close case.

INSTITUTIONALIZED INDIVIDUAL	VERIFICATION
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<p>1. Date of Institutionalization: _____</p> <p>2. Assets disposed for less Than FMV within 60 months? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>3. Penalty for disposal? <input type="checkbox"/> Yes <input type="checkbox"/> No Date(s) disposed: _____ Amount disposed: _____ Period ineligible for LTC: _____ to _____.</p> <p>4. Community spousal support? <input type="checkbox"/> Yes (complete DHS 1171) <input type="checkbox"/> No a. Amount to community spouse: \$ _____</p> <p>5. Dependent support? <input type="checkbox"/> Yes <input type="checkbox"/> No a. Child residing with community spouse? <input type="checkbox"/> Yes <input type="checkbox"/> No b. Child residing in institutionalized individual's home without community spouse? <input type="checkbox"/> Yes <input type="checkbox"/> No c. Amount to dependent family member \$ _____</p> <p>6. Total assets (joint and/or individually owned): \$ _____ a. Amount transferred to community spouse: \$ _____ b. Amount retained by institutionalized spouse: \$ _____ c. 90th Day transfer due date: _____</p> <p>7. Home property/life estate? <input type="checkbox"/> Yes <input type="checkbox"/> No a. Equity value of home property/life estate: \$ _____ b. If home equity exceeds \$750,000, is spouse, child under age 21, or a blind or disabled child residing in the individual's home? <input type="checkbox"/> Yes <input type="checkbox"/> No If "NO", ineligible for LTC. c. Intent to return? <input type="checkbox"/> Yes <input type="checkbox"/> No Home property exempt? <input type="checkbox"/> Yes <input type="checkbox"/> No Date DHS 1167 completed: _____ Date DHS 1169/1169A completed: _____ Date DHS 1169/1169A sent to MQD/FO: _____</p> <p>8. Interest in an annuity? <input type="checkbox"/> Yes <input type="checkbox"/> No Actuarially sound? <input type="checkbox"/> Yes <input type="checkbox"/> No Is annuity subject to transfer of asset penalty? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>9. Is there a trust? <input type="checkbox"/> Yes <input type="checkbox"/> No Whose assets are in the trust? _____ Who is beneficiary of the trust? _____</p>	
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Additional Documentation: