INSTRUCTIONS
DHS 1100 (Rev. 10/14)

APPLICATION FOR HEALTH COVERAGE & HELP PAYING COSTS

PURPOSE:
The DHS 1100, Application for Health Coverage & Help Paying Costs (Rev. 10/14) shall be used as the basic document as the Departmental application for anyone applying for medical assistance.

GENERAL INSTRUCTIONS:

1. An individual shall complete the DHS 1100 when applying for medical assistance. The DHS 1100 shall be completed and signed by an applicant who is an adult or a responsible household member. If the applicant is a minor, is incapacitated and incapable of acting on his or her own behalf, or is deceased, the applicant may designate a trusted person to act as their Authorized Representative on all matters relating to their application. This includes getting information needed to complete the application and signing of the application on the applicant's behalf.

2. The Department:
   a) Shall provide assistance to any applicant with the DHS 1100 in person, over the telephone, and online, in a manner that is accessible to individuals with disabilities and those who are limited English proficient, in accordance with the Disabilities Act and by section 504 of the Rehabilitation Act and Title VI of the Civil Rights Act of 1964.

   b) May choose to designate organizations, subject to certification by the department or designee to provide assistance to an applicant with the application process, to include but not be limited to:
      - Completion or submission of the DHS 1100 for medical assistance.
      - Interaction with the department on the status of the application.
      - Assistance with responses to the Department; and
      - Case management following the initial approval and subsequent redeterminations in compliance with federal requirements.

   c) Shall establish for department-certified application counselors providing assistance to an applicant:
      1) A designated web portal exclusively for their use for purposes of providing assistance under HAR §17-1711.1-11;
      2) A secure mechanism to ensure they are able to perform only those duties for which they are certified; and
      3) Procedures to ensure that an applicant is:
         - Informed of the functions and responsibilities of the certified application counselor;
         - Able to authorize a certified application counselor to receive confidential information regarding the applicant related to the application; and
         - Informed that services provided by the certified application counselor is provided free of charge.

3. The DHS 1100 may be submitted to the Department by any of the following methods:
   - Via the Department's designated internet web site(s);
   - By telephone;
   - Via the United States Postal Service;
   - In person; or
   - Through other commonly available electronic means.

   NOTE: An applicant who is unable to complete the entire application must provide his/her name, address and a signature of the applicant or authorized representative.

Additional information as determined by the Department may be requested when coverage for long-term care services is being requested.

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STEP 1 Tell us about yourself.

An adult or responsible household member who shall be identified as the Contact Person or Authorized Representative shall complete the DHS 1100 by providing the following information as requested:

1.	First name, Middle name, Last name, & Suffix	Enter first, middle, last name, & suffix
2.	Home address (Leave blank if you don't have one.)	Enter home address
3.	Apartment or suite number	Enter apartment or suite number.
4.	City	Enter city
5.	State	Enter state
6.	ZIP code	Enter ZIP code
7.	County	Enter county
8.	Mailing address (if different from home address.)	Enter mailing address
9.	Apartment or suite number	Enter apartment or suite number
10.	City	Enter city
11.	State	Enter state
12.	ZIP code	Enter ZIP code
13.	County	Enter county
14.	Phone number	Enter (_ _ _) _ _ _ - _ _ _ _
15.	Other phone number	Enter (_ _ _) _ _ _ - _ _ _ _
16.	Do you want to get information about this application by email?	Check Yes or No. If Yes, enter email address.
17.	What is your preferred spoken language (if Not English)	Enter your preferred spoken language
18.	What is your preferred written language (If Not English)	Enter your preferred written language
19.	How many members live with you?	Enter number of individuals
20.	Is any family member you usually live with incarcerated (detained or jailed) or residing in the Hawaii State Hospital?	Check Yes or No If yes list their name(s)

STEP 2 Tell us about your family.

The Contact Person or Authorized Representative A responsible household member shall provide the information about all family members who live in the household including a spouse/partner, any children living in the household, and anyone else included in the household's federal income tax return. Note: Applicants do not need to file taxes to get health coverage.

STEP 2: PERSON 1 (Start with yourself)

1.	First name, Middle name, Last name, & Suffix	Enter first, middle, last name, & suffix
2.	Relationship to you?	Pre-populated (SELF)
3.	Date of birth	Enter date of birth as month-month/day-day/year-year-year-year (mm/dd/yyyy)
4.	Gender	Check Male or Female.
5.	Social security number (SSN)	Enter _ _ _ - _ _ - _ _ _ _.
6.	Do you plan to file a federal income tax return NEXT YEAR?	Check Yes or No. If Yes, complete questions a to c. If No, skip to question c.
	a. Will you file jointly with a spouse?	Check Yes or No. If Yes, enter name of spouse. If No, go to question b.
	b. Will you claim any dependents on your tax return?	Check Yes or No. If Yes, list name(s) of dependents. If No, go to question c.
	c. Will you be claimed as a dependent on someone's tax return?	Check Yes or No. If Yes, please list the name of the tax filer and indicate relationship to tax filer. If No, go to question 7.
7.	Are you pregnant?	Check Yes or No. If Yes, enter number of babies expected and the expected due date. If No, go to question 8.
	a. If yes, how many babies are expected during this pregnancy? _____ Expected Due Date _____	
8.	Do you need health coverage?	Check Yes or No. If Yes, answer all the questions on page 2. If No, skip to the income questions on page 3. Leave the rest of this page blank.
9.	Do you have a disability that will last more than (12) months?	Check Yes or No. If Yes complete questions a to d. If No, go to question 10. Check Yes in either Nursing Facility or in my Home in the Community.
	a. Do you currently receive long term care nursing services: Yes, in a nursing home or Yes, in my home in the community.	a. Check Yes or No, If Yes, check appropriate box. If No, go to question b.
	b. Have you received long term care nursing services in the last three (3) months?	b. Check Yes or No. If Yes, enter what date(s) services were received then go to question c.
	c. Do you think you need long term care nursing services now?	c. Check Yes or No then go to question d.
	d. Do you receive Supplemental Security Income (SSI)?	d. Check Yes or No then go to question 10.

10.	Did you receive any medical services in the past (10) calendar days immediately, prior to the date of application?	Check Yes or No. If Yes, enter date(s). If No, go to question 11.
11.	Are you a U.S. citizen or U.S. national?	Check Yes or No. If Yes, skip to question 13.
12.	If you aren't a U.S. citizen or U.S. national, please provide the information below. a. Immigration document type b. Document ID number c. When did you enter the U.S.? d. Are you a citizen of the Federated State of Micronesia, the Republic of the Marshall Islands, and Palau? e. Are you, or your spouse or parent, a veteran or an active-duty member of the U.S. military?	a. Enter Immigration document type b. Enter Document ID number c. Enter Date entered U.S. d. Check Yes or No. e. Check Yes or No.
13.	Are you the primary or one of the primary person (s) taking care of a child under age 19 years that lives with you?	Check Yes or No.
14.	Were you in foster care at age 18 or older in Hawaii?	Check Yes or No.
15.	Are you a full time student?	Check Yes or No.
16.	If Hispanic/Latino, ethnicity (OPTIONAL – check all that apply.)	Check all Hispanic/Latino, ethnicity as applicable. If your ethnicity is not listed, enter under Other as appropriate.
17.	Race (OPTIONAL - check all that apply.)	Check all race as applicable. If your race is not listed, enter under Other as appropriate.

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STEP 2: PERSON 1 (Continue with yourself)
Current Job & Income Information

☐ Employed	Check if employed, skip to question 18.
☐ Self-Employed	Check if self-employed, skip to question 27.
☐ Not Employed	Check if not employed, skip to question 28.

CURRENT JOB 1:

18.	Employer name and address	Enter employer name and address
19.	Employer phone number	Enter (_ _ _) _ _ _ - _ _ _ _
20.	Wages/tips (before taxes)	Check when and enter amount paid.
21.	Average hours worked each WEEK	Enter average hours worked each week.

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

22.	Employer name and address	Enter employer name and address
23	Employer phone number	Enter (_ _ _) _ _ _ - _ _ _ _
24.	Wages/tips (before taxes)	Check when and enter amount paid.
25.	Average hours worked each WEEK	Enter average hours worked each week.
26.	In the past year, did you:	Check status of employment.
27.	If self-employed, answer the following questions: a. Type of work: b. How much net income (profits once business expenses are paid) will you get from this self-employment this month?	a. Enter type of work b. Enter net income received.
28.	OTHER INCOME THIS MONTH:	Check all that apply and enter amount and frequency.
29.	DEDUCTIONS:	Check all that apply and enter amount and frequency.
30.	YEARLY NET INCOME:	Complete only if your income changes from month to month. If you don't expect changes to your monthly income, skip to the next person.
	Your total income this year	Enter the total amount for this year
	Your total income next year (if it will be different)	Enter the expected amount for next year.

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STEP 2: PERSON 2

The Contact Person or Authorized Representative shall provide the information about all family members who live in the household including a spouse/partner, any children living in the household, and anyone else included in the household's federal income tax return. If federal income tax returns are not filed, still include anyone else who lives in the household.

1.	First, Middle, Last name, & Suffix	Enter First, Middle, Last name, & suffix.
2.	Relationship to you?	Enter relationship to PERSON 1.
3.	Date of birth (mm/dd/yyyy)	Enter date of birth (mm/dd/yyyy)
4.	Gender	Check Male or Female.
5.	Social Security number (SSN)	Enter _ _ _ - _ _ - _ _ _ _.
6.	Does PERSON 2 live at the same address as you?	Check Yes or No. If Yes, go to the next question. If No, list different address.
7.	Does PERSON 2 plan to file a federal income tax return NEXT YEAR? a. Will PERSON 2 file jointly with a spouse? b. Will PERSON 2 claim any dependents on his or her tax return? c. Will PERSON 2 be claimed as a dependent on someone's tax return?	Check Yes or No. If Yes, answer question a to c. If No, skip to question c. a. Check Yes or No. If Yes, enter name of spouse. b. Check Yes or No. If Yes, enter name(s) of dependents. c. Check Yes or No. If Yes, enter name of tax filer and indicate relationship to tax filer.

How is PERSON 2 related to the tax filer?

8. Is PERSON 2 pregnant?
If yes, how many babies are expected during this pregnancy? _____
Expected Due Date _____
Check Yes or No. If Yes, enter the number of babies expected and the expected due date.

9. Does PERSON 2 need health coverage?
Check Yes or No. If Yes, answer all the questions below. If No, SKIP to the income questions on page 5. Leave the rest of this page blank.

10. Does PERSON 2 have a disability that will last more than twelve (12) months?
Check Yes or No.
If Yes, complete questions a to d. If No, go to question 11.

a. Does PERSON 2 currently receive long term care nursing services:
Yes, in a nursing facility
Yes, in my home in the community
a. Check appropriate box. If No, go to question b.

b. Has PERSON 2 received long term care nursing services in the last three (3) months?
b. Check Yes or No. If Yes enter what date(s) services were received then go to question c.

c. Does PERSON 2 need long term care nursing services now?
c. Check Yes or No then go to question d.

d. Does PERSON 2 receive Supplemental Security Income (SSI)?
d. Check Yes or No then go to question 11

11. Did PERSON 2 receive any medical services in the past (10) calendar days immediately prior to the date of this application?
Check Yes or No. If Yes, enter date(s) of when the medical service(s) was received.

12. Is PERSON 2 a U.S. citizen or U.S. national?
Check Yes or No. If Yes skip to question 14. If No, go to question 13.

13. If PERSON 2 isn't a U.S. citizen or U.S. national, please provide the information for questions a to d.

a. Immigration document type
a. Enter type of immigration document

b. Document ID number
b. Enter document ID number

c. When did PERSON 2 enter the U.S.?
c. Enter Date

d. Is PERSON 2 a citizen of the Federated States of Micronesia, the Republic of the Marshall Islands, and Palau?
d. Check Yes or No.

e. Is PERSON 2, or their spouse or parent a veteran or an active-duty member in the U.S. military?
e. Check Yes or No.

14.	Is PERSON 2 the primary or one of the primary person(s) taking care of a child under the age 19 years that lives with you?	Check Yes or No.
15.	Was PERSON 2 in foster care at age 18 or older in Hawaii?	Check Yes or No.
16.	Is PERSON 2 a full time student?	Check Yes or No.
17.	If Hispanic/Latino, ethnicity (OPTIONAL – check all that apply.)	Check all Hispanic/Latino, ethnicity as applicable. If your ethnicity is not listed, enter under Other as appropriate.
18.	Race (OPTIONAL - check all that apply.)	Check all race as applicable. If your race is not listed, enter under Other as appropriate.

STEP 2: PERSON 2

Current Job & Income Information

☐ Employed	Check if employed, go to question 19.
☐ Self-Employed.	Check if self-employed, skip to question 28.
☐ Not Employed.	Check if not employed, skip to question 29.

CURRENT JOB 1:

19.	Employer name and address	Enter employer name and address
20.	Employer phone number	Enter (_ _ _) _ _ _ - _ _ _ _
21.	Wages/tips (before taxes)	Check when and enter amount paid.
22.	Average hours worked each WEEK	Enter hours worked.

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

23.	Employer name and address	Enter employer name and address
24.	Employer phone number	Enter (_ _ _) _ _ _ - _ _ _ _
25.	Wages/tips (before taxes)	Check when and enter amount paid.
26.	Average hours worked each week	Enter average hours worked each week.
27.	In the past year, did PERSON 2:	Check employment status.
28.	If self-employed, answer the following questions: a. Type of work: b. How much net income (profits once business expenses are paid) will you get from this self-employment this month?	 a. Enter type of work b. Enter net income received.
29.	OTHER INCOME THIS MONTH:	Check all applicable income and enter the amount and frequency.
30.	DEDUCTIONS:	Check all applicable deductions and enter the amount and frequency.

31.	YEARLY INCOME:	Complete only if PERSON 2's income changes from month to month. If PERSON 2's monthly income is Not expected to change, add another person or skip to the next section.
	PERSON 2's total income this year	Enter the total amount for this year
	PERSON 2's total income next year (if you think it will be different)	Enter the expected amount for next year.

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STEP 3 American Indian or Alaska Native (AI/AN) family member(s)

1.	Are you or is anyone in your family American Indian or Alaska Native?	Check Yes or No. If No, skip to Step 4. If Yes, go to Appendix B.

STEP 4 Your Family's Health Coverage

Answer these questions for anyone who needs health coverage.

1.	Does anyone have health coverage or health insurance other than Medicaid?	Check Yes or No. If Yes, check the type of coverage and enter the person(s) name(s) on the line provided and additional information as appropriate. If the health coverage is not listed, enter as Other and complete as appropriate.
2.	Is anyone listed on this application offered health coverage from a job? Check Yes even if the coverage is from someone else's job, such as a parent or spouse.	Check Yes or No. If Yes, complete Appendix A. If No, go to Step 5.
	Is this a state employee benefit plan?	Check Yes or No.

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STEP 5 Read & sign this application.

The contact person or the authorized representative who completed this application shall sign and date certifying that he/she:

- Is signing this application under penalty of perjury and know that he/she may be subject to penalties under state or federal law if false or untrue information is provided.
- Must report to Department of Human Services or the Hawaii Health Connector any changes or differences from what is written on the application at mybenefits.hawaii.gov or call 1 (877) 628-5076.
- Is aware that the changes may affect applicant(s) eligibility.
- Knows that under federal law, discrimination isn't permitted on the basis of race, color, national origin, gender, age, sexual orientation, gender, identity, or disability and he/she can file a complaint of discrimination under www.hhs.gov/ocr/office/file.
- Understands that the Department of Human Services and the Hawaii Health Connector will obtain information to verify eligibility with electronic databases to include but not limited to the Internal Revenue Services (IRS), Social Security Administration (SSA), Department of Homeland Security (DHS) or a consumer reporting agency, and is aware that if the information does not match the applicant(s) information the applicant(s) may be asked to send proof.

Renewal of coverage in future years

The contact person or the authorized representative may identify the number of	Check Yes or No. If Yes, check the appropriate years

years his/her eligibility is to be renewed automatically.

If anyone on this application is eligible for Medicaid

The contact person or the authorized representative agrees to allow the Medicaid agency to pursue any payment from other health insurance, legal settlements, or other third parties and the right to pursue medical support from a spouse or parent; and as appropriate will be asked to cooperate with the agency that collects medical support from an absent parent. If cooperating with medical support will harm him/herself or their children, he/she can tell Medicaid and may not have to cooperate. The contact person or authorized representative also agrees to cooperate with the Department of Human Services, Federal Quality control reviewers or auditors if their case is selected for a review.

Check Yes or No if any child on this application has a parent living outside of the home.

My right to appeal

If the person or the authorized representative thinks the Department of Human Services or the Hawaii Health Connector made a mistake, he/she:

- Can appeal its decision and find out how to appeal by contacting someone at **1-877-628-5076**.
- Can be represented in the process by someone other than him/herself.
- Will have their eligibility and other important information explained to him/her.

Sign this application.

The contact person or authorized representative who filled out Step 1 should sign and date this application. If the person signing is the authorized representative, he/she may sign on the signature line as long as they have provided the information required in Appendix C.

Signature	Enter signature.
Date	Enter (mm/dd/yyyy)

STEP 6 Mail your signed application to:

Completed applications can be mailed or dropped off to the Med-QUEST Eligibility office as listed.

Information is also provided as to how to register to vote.

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APPENDIX A

Health Coverage from Jobs

Completion of Appendix A is only required for a household member who is eligible for health coverage from a job. A copy must be attached for each job that offers coverage.

Tell us about the job that offers coverage.
The Employer Coverage Tool must be taken to the employer who offers coverage to help complete the questions. Appendix A only needs to be submitted with the application that is sent in.

EMPLOYEE Information

1.	Employee name (First, Middle, Last)	Enter employee's first, middle, and last name.
2.	Employee Social Security number	Enter employee's _ _ _ - _ _ - _ _ _ _.

EMPLOYER Information

3.	Employer name	Enter employer name
4.	Employer Identification Number (EIN)	Enter EIN
5.	Employer address	Enter employer address
6.	Employer phone number	Enter (_ _ _) _ _ _ - _ _ _ _
7.	City	Enter city
8.	State	Enter state
9.	Zip Code	Enter Zip code
10.	Who can we contact about employee health coverage at this job?	Enter name of employer health coverage contact person.
11.	Phone number (if different from above)	Enter (_ _ _) _ _ _ - _ _ _ _
12.	Email address	Enter email address
13.	Are you currently eligible for coverage offered by this employer, or will you become eligible in the next 3 months?	Check Yes or No. If Yes, complete question 13a and list the names of anyone else who is eligible for coverage from this job. If No, go to Step 5 in the application.
	a. If you are in a waiting or probationary period, when can you enroll in coverage?	Enter (mm/dd/yyyy)

Tell us about the health plan offered by this employer.

14.	Does the employer offer a health plan that meets the minimum value standard*?	Check Yes or No.
15.	For the lowest-cost plan that meets the minimum value standard* offered only to the employee (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/she received the maximum discount for any tobacco cessation programs, and did Not receive any other discounts based on wellness programs.	
	a. How much would the employee have to pay in premiums for this plan?	a. Enter amount of premium.
	b. How often?	b. Enter frequency of premium paid by employee. If the plan year will end soon and you know that the health plans offered will change, go to

		question 16. If you don't know, stop and return form to employee.
16.	What change will the employer make for the new plan year (if known)?	Check if health coverage will or won't be offered. If health coverage will be offered premium should reflect the discount for wellness programs. (See question 15.)
	a. How much would the employee have to pay in premiums for that plan?	a. Enter amount to be paid in premium.
	b. How often?	b. Check frequency of premium paid.

* An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is No less than 60 percent of such costs (Section 36B(c)(2)(c)(ii) of the Internal Revenue Code of 1986).

EMPLOYER COVERAGE TOOL

Completion of the Employer Coverage Tool will help answer questions in Appendix A about any employer health coverage that the individual is eligible for (even if it's from other person's job, like a parent or spouse). The information in the numbered boxes matches the boxes on Appendix A. One tool must be completed for each employer that offers health coverage.

EMPLOYEE Information

The employee needs fill out this section.

1.	Employee name (First, Middle, Last)	Enter employee first, middle, last name
2.	Employee Social Security number	Enter employee _ _ _ - _ _ - _ _ _ _

EMPLOYER Information

Ask the employer for this information.

3.	Employer Name	Enter employer name
4.	Employer Identification Number (EIN)	Enter EIN
5.	Employer address	Enter employer address
6.	Employer phone number	Enter (_ _ _) _ _ _ - _ _ _ _
7.	City	Enter city
8.	State	Enter state
9.	ZIP Code	Enter ZIP code
10.	Who can we contact about employee health coverage at this job?	Enter name of employer health coverage contact person.
11.	Phone number (if different from above)	Enter (_ _ _) _ _ _ - _ _ _ _
12.	Email address	Enter email address
13.	Is the employee currently eligible for coverage offered by this employer, or will you become eligible in the next 3 months?	Check Yes or No. If Yes, complete question a. If No, stop and return form to employee.
	a. If the employee is not eligible today, including as a result of a waiting of probationary period, when is the employee eligible for coverage?	Enter (mm/dd/yyyy)

Tell us about the health plan offered by this employer.

Does the employer offer a health plan that covers an employee's spouse or dependent?

14.	Does the employer offer a health plan that meets the minimum value standard*?	Check Yes or No. If Yes, check spouse or dependents. If No, go to question 14.
15.	For the lowest-cost plan that meets the minimum value standard* offered only to the employee (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/she received the maximum discount for any tobacco cessation programs, and did Not receive any other discounts based on wellness programs.	Check Yes or No. If Yes, go to question 15. If No, stop and return form to employee.
	a. How much would the employee have to pay in premiums for this plan?	a. Enter amount of premium.
	b. How often?	b. Check frequency of premium.

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year?	Check if employer will or won't offer health coverage. If offered, premium should reflect the discount for wellness programs. (See question 15.)
a. How much will the employee have to pay in premiums for that plan?	Enter amount paid in premium.
b. How often?	Check frequency of premium.

* An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is No less than 60 percent of such costs (Section 36B(c)(2)(c)(ii) of the Internal Revenue Code of 1986).

APPENDIX B

American Indian or Alaska Native Family Member (AI/AN)

Completion of Appendix B is only required if the individual or a family member are American Indian or Alaska Native. Appendix B must be submitted with the Application for Health Coverage & Help Paying Costs.

Tell us about your American Indian or Alaska Native family member(s).

American Indians and Alaska Natives can get services from the Indian Health Services, tribal health programs, or urban Indian health programs. They also may not have to pay cost sharing and may get special monthly enrollment periods. Answer the following questions to make sure your family gets the most help possible.

NOTE: If you have more people to include, make a copy of this page and attach.

AI/AN PERSON 1

1.	Name (First name, Middle name, Last name)	Enter first, middle, and last name
2.	Member of a federally recognized tribe?	Check Yes or No. If Yes, enter name of tribe.
3.	Has this person ever gotten a service from the Indian Health Service, a tribal Health program, or urban Indian health	Check Yes or No.

	Program, or through a referral from one of these programs?	
	If No, is this person is eligible to get services from the Indian Health Service, a tribal Health program, or urban Indian health Program, or through a referral from one of these programs?	Check Yes or No.
4.	Certain money received may not be counted for Medicaid or the Children's Health Insurance Program (CHIP). List any income (amount and how often) reported on your application that includes money from these sources: • Per capita payments from a tribe that come from natural resources, usage rights, leases, or royalties • Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior (including reservations and former reservations) • Money from selling things that have cultural significance	Enter amount and frequency money received.

AI/AN PERSON 2

Refer to instructions under **AI/AN PERSON 1**.

APPENDIX C

Assistance with Completing this Application

You can choose an authorized representative.

1.	Name of authorized representative (First name, Middle name, Last name)	Enter first, middle, and last name
2.	Address	Enter address
3.	Apartment or suite number	Enter apartment or suite number
4.	City	Enter city
5.	State	Enter state
6.	ZIP code	Enter ZIP code
7.	Phone number	Enter (_ _ _) _ _ _ - _ _ _ _
8.	Organization name	Enter organization name
9.	ID number (if applicable)	Enter ID number

An individual who is signing below is authorizing someone to sign their application, get official information about this application, and act on their behalf on all future matters with this agency.

10.	Your signature	Enter signature.
11.	Date	Enter (mm/dd/yyyy)

Authorized Representative

If an authorized representative is designated they agree to maintain the confidentiality of information provided to the applicant(s) by the State of Hawaii Department of Human Services. By signing and completing information requested below, the authorized representative also agrees to adhere to the regulations relevant to the State and Federal Laws covering conflicts of interest and confidentiality of information.

Signature of Authorized Representative	Enter Signature of Authorized Representative
Telephone	Enter Telephone
Date	Enter Date
Street Address	Enter Street Address
City	Enter City
State	Enter State
Zip Code	Enter Zip Code

As applicable (I am a provider of staff member or volunteer of an organization)

PRINT Name of Individual	PRINT Name of Individual
PRINT Name of Provider/Organization	PRINT Name of Provider/Organization

For certified application counselors, navigators, agents, and brokers only.

1.	Application start date	Enter (mm/dd/yyyy)
2.	First name, Middle name, Last name & Suffix	Enter first, middle, last name & suffix
3.	Organization name	Enter organization name
4.	ID number (if applicable)	Enter ID number