STATE OF HAWAII
Department of Human Services

MED-QUEST DIVISION

OFFICIAL USE ONLY
Case Name:
Case No.:
Received Date:

CHANGE OF CIRCUMSTANCE REPORT FORM

You must report any changes to your household (if anyone moves in or out of your household, if anyone gets married, becomes pregnant, or gives birth to a child), a change in address, income or job status **within 15 days of the event.** If this report does not provide enough room to document a change, attach a sheet of paper with the additional information. You may also report changes online at https://medical.mybenefits.hawaii.gov, by telephone or in person. Failure to report changes may result in benefits being denied, terminated or stopped. Auth.: H.A.R. §17-1712.1-4

Primary Individual Name: (Last, First, MI)	Date of Birth: (mm/dd/yyyy)	Client ID or SSN:
Current Address (Street, City, State, Zip code):		Phone:
Check one if you are completing on behalf of the Medicaid beneficiary		**Must Check one:**
☐ Authorized Representative (DHS1121)	☐ Legal Guardian, Power of Attorney, or Conservator (Legal document)	☐ **ON FILE or** ☐ **ATTACHED**
Name: (Last, First, MI)		
Requests for change of circumstance by an Authorized Representative, Legal Guardian, Power of Attorney (POA) or Conservator on behalf of the Medicaid beneficiary requires proof of authorization. If the Department does not have a signed authorization on file from the beneficiary, the request for a change of circumstance on the Medicaid beneficiary's behalf will not be processed until proof is received by the Department.		

INTERPRETER REQUESTED: ☐ **YES** ☐ **NO** **LANGUAGE REQUESTED:** _____

☐ **SECTION 1 - REQUESTING CLOSURE OF MEDICAL COVERAGE**

Do you want to STOP your Med-QUEST Medical assistance for everyone in your household? ☐ Yes ☐ No

Effective Date: (mm/dd/yyyy)

Reason:

☐ **SECTION 2 - NAME CHANGE (Attach copy of legal document.)**

Reason for change: (Complete section 5 if applicable)	☐ Marriage ☐ Divorce ☐ Adoption/Court Order ☐ Other-Specify:
From:	(Last, First, MI):
To:	(Last, First, MI):

☐ **SECTION 3 - ADDRESS &/OR TELEPHONE CHANGE (This change will apply to ALL household members in your case, if this is incorrect, please specify in Section 8 who this change applies to.)**

New Residence:	(Street No. & Name)	(City)	(State)	(Zip Code)
New Mailing:	(Street No. & Name)	(City)	(State)	(Zip Code)
New Phone Number:	Type: ☐ Home ☐ Cell ☐ Work	Phone Number:		
Email Address:				

☐ **SECTION 4 - REPORT OR CHANGE OF PREGNANCY**

Pregnant Woman Name: (Last, First, MI)	Date of Birth: (mm/dd/yyyy)	Client ID or SSN:

Number of Babies Expected:	Due Date: (mm/dd/yyyy)	End Date of Pregnancy: (mm/dd/yyyy)

☐ **SECTION 5 - OTHER HEALTH COVERAGE**

Were <u>you or any one in your household</u> involved in an incident or accident where someone else may be responsible for your medical expenses? If yes, we will contact you. ☐ Yes ☐ No

Who Was Involved	Accident Date	Who May Be Responsible/Insurance Company

Is anyone <u>in this household</u> currently enrolled in health coverage other than Medicaid (QUEST Integration)?
☐ Yes ☐ No

If Yes:

Name	Health Insurance Carrier/Plan	Policy ID	Start Date	End Date

☐ **SECTION 6 - CHANGE IN HOUSEHOLD MEMBERS**

HOUSEHOLD MEMBER REMOVED:

Name	Reason (see examples below)	Date removed

Examples of reasons for household member removal:

- In prison or Hawaii State Hospital
- Other Reason (please explain)
- Moved Out
- Deceased
- In prison or Hawaii State Hospital
- Other Reason (please explain)
- Divorced or Legally Separated
- Nursing Home or Community Care Foster Family Home
- Divorced or Legally Separated
- Nursing Home or Community Care Foster Family Home

NEW HOUSEHOLD MEMBER:

If you need to ADD more than one (1) new member, please make a copy of this page and the next and respond to the following questions for each household member added or contact* Customer Service at 1-800-316-8005 (TTY: 711 or 1-800-603-1201) *for additional assistance:

New Member Name (First, Middle, Last, Suffix)

If new member is a newborn, please provide mother and father name below:

Mother's Name:	Father's Name:

Applying for Medical Coverage? ☐ **YES** ☐ **NO**

Medical Services received within the past 90 days? ☐ **YES** ☐ **NO** If yes, date:

Gender	Date of Birth (mm/dd/yyyy)	**Social Security Number

***A Social Security number (SSN) **must be provided** for each individual (including children) **applying for Medical assistance**. We may contact your household if additional information is needed. Benefits may be delayed if requested information is not received. If help is needed to get an SSN or a replacement SSN card, call 1-800-772-1213 or visit socialsecurity.gov. TTY users should call 1-800-325-0778*

Married? ☐ **YES** ☐ **NO**	If Yes, Name of Spouse:

Gross monthly income (total income **before** taxes or other deductions):

Plan to file a federal income tax return? ☐ **YES** ☐ **NO** Filing jointly with spouse? ☐ **YES** ☐ **NO**

Will claim any tax dependents on their tax return? ☐ **YES** ☐ **NO**

Write name(s) of tax dependents:

Will be claimed as a tax dependent on someone's tax return? ☐ **YES** ☐ **NO**

If yes, name of the tax filer: *Relationship:

Is the new member pregnant? ☐ **YES** ☐ **NO** Expected Due Date: How many expecting:

Are you a U.S. Citizen/National? ☐ **YES** ☐ **NO**

If No, does the new member have eligible immigration status? ☐ **YES** ☐ **NO**

Date of Entry _____ Alien or I-94 No. _____

Immigration Document Type (i.e. I-551, Visa, etc.):	Status type

Name as it appears on your immigration doc.

Passport Number. other card number.

SEVIS ID or Expiration Date (optional)	Category Code

Is the new member claimed as a tax dependent on any of the household members taxes? ☐**YES** ☐ **NO**

If yes, please list the name of the household member that they are claimed as a tax dependent below.

Examples of household relationships (including step where applicable) below:

- Married
- Parent
- Child
- Sibling
- Under Primary Care
- Grandparent
- Uncle/Aunt
- Niece/Nephew
- Cousin
- Grandchild
- Foster Parent
- Foster Child
- Unmarried Partner or Domestic Partnership
- Not Related
- Other Related (please explain)

How is the new member related to the Primary Contact on this Form? (*examples of relationship on previous page.)

If there are other members in this household, (living at the "current address" listed) please list who they are and how the new member is related to them below:

Current household member:	Relationship to new member:
1.	1.
2.	2.
3.	3.
4.	4.
5.	5.
6.	6.

If there are more than (6) people in this household please make a copy of this page, complete and attach.

If you need to report multiple changes, please make a copy of this page or attach additional pages. If you need assistance or prefer to talk directly with one of our eligibility staff, you can contact Customer Service at 1-800-316-8005 (TTY: 711 or 1-800-603-1201). Changes can also be reported online at https://medical.mybenefits.hawaii.gov or in our offices.

☐ SECTION 7 - CHANGE IN HOUSEHOLD INCOME

Has anyone in your household stopped working, changed jobs or had a change to their existing income?

☐ Yes, complete section below. **☐ No**

Name: (Last, First, MI)	Date of Birth: (mm/dd/yyyy)	Client ID (or SSN optional):

CHANGE TO EXISTING INCOME

Employer Name/Source of Income:

Please select the reason for this change

☐ Stopped working or stopped receiving income

Reason: _____ (example: quit job, medical leave, layoff)

Last day of work: (mm/dd/yyyy)

☐ Started working fewer hours at an existing job

Effective Date: (mm/dd/yyyy)

Average hours per week:

☐ Started working more hours at an existing job

Effective Date: (mm/dd/yyyy)

Average hours per week:

☐ Received a raise at an existing job

Effective Date: (mm/dd/yyyy)

New Income Amount: $_____

Paid: ☐ Weekly ☐ Monthly ☐ Twice a month ☐ Every 2 weeks

If paid hourly, enter new Hourly Pay: $_____ Average Hours per Week: _____

Has anyone in your household started a new job or receives a new source of income?

☐ Yes, complete section below. **☐ No**

Name: (Last, First, MI)	Date of Birth: (mm/dd/yyyy)	Client ID (or SSN optional):

REPORTING NEW INCOME

Employer Name/Source of Income:

Please select the reason for this change

☐ Started a new job (including adding a second or additional job)

☐ Other _____

Start Date:

New Income Amount: $_____ Paid: ☐ Weekly ☐ Monthly ☐ Twice a month ☐ Every 2 weeks

If paid hourly, enter Hourly Pay: $_____ Average Hours per Week: _____

☐ **SECTION 8 – COVERAGE FOR AGED, BLIND, or DISABLED HOUSEHOLD MEMBERS**

Has anyone in your household recently turned 65, started receiving SSI, or become blind or disabled?

☐ **Yes, complete the section below** ☐ **No. SKIP TO SECTION 9**

Name (First, Middle, Last, Suffix)	Determined Blind/Disabled	Age 65 or older	Receiving SSI	Medicare
	☐	☐	☐	☐
	☐	☐	☐	☐

Does anyone in your household need Long-term Care Services?

☐ **Yes, complete section A below** ☐ **No, skip to section B**

A. **Tell us who needs LTC Services.**

1. First name, Middle initial, Last name, & Suffix	2. Date of Birth (mm/dd/yyy)
3. Have you been certified as blind or disabled (i.e. receiving Supplemental Security Income (SSI) or Social Security blind/disabled benefits)? ☐ Yes ☐ No. If no, you may be required to complete additional forms.	
4. Where do you have/want to have LTC services provided to you? ☐ At home: _____ Service Start Date:_____ ☐ Nursing Facility Name: _____ Admission Date: _____ ☐ Community Care Foster Family Home Name: Admission Date: _____	
5. Marial Status: ☐ Single ☐ Divorced ☐ Widow(er) ☐ Married	

Section B: Tell us about your assets

Do you, your spouse or dependent(s) own any assets? Check YES or NO for every type of asset listed below. If your assets are not on this list, check YES for Other Assets and state type of asset it is.

☐ **Yes, complete the section below.** ☐ **No**

Please provide the following information as of the first day of this month.

Yes	No	Assets	Owner's Name	Bank or Company Name	Equity Value
☐	☐	Checking Accounts (List all)			$
☐	☐	Savings Accounts (List all)			$
☐	☐	Cash			$
☐	☐	Income Tax Refunds			$
☐	☐	Stocks and Bonds			$
☐	☐	Money Market Accounts, CDs, and Time Certificates			$
☐	☐	IRA, Keogh, and Deferred Compensation			$
☐	☐	Burial Plans: Total No.			$
☐	☐	Burial Plots: Total No.			$
☐	☐	Life Insurance (Surrender Cash Value)			$
☐	☐	Family or Individual Trust or Trust Funds			$
☐	☐	Business Equity (Self-Employed)			$
☐	☐	Boats and Trailers			$
☐	☐	Jewelry, Diamonds, Gold, Silver, etc.			$
☐	☐	Other Assets:			$

Do you and/or your spouse own a home property that you currently reside in? (You may need to complete additional forms.)

☐ **Yes, complete the section below.** ☐ **No**

Owner's Name	Property Address	Equity Value
		$
		$

Do you and/or your spouse own other properties other than your home property?

☐ **Yes, complete the section below.** ☐ **No**

Owner's Name	Property Address	Market Value
		$
		$

Did you and/or your spouse purchase life estate interest in a property of another?

☐ **Yes, complete the section below.** ☐ **No**

Owner's Name	Transaction Date	Property Address	Equity Value
			$
			$

Did you and/or your spouse sell, trade, give away money, property, or other assets in the past 60 months? Or did you and/or your spouse make transfers into a trust within the past 60 months?

☐ **Yes, complete the section below.** ☐ **No**

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

Do you and/or your spouse own any annuities? (You may be asked to complete additional forms.)

☐ **Yes, complete the section below.** ☐ **No**

Owner's Name	Issuance Date	Name and Address of Annuity Company

Do you and/or your spouse have a promissory note, loan, or mortgage?

☐ **Yes, complete the section below.** ☐ **No**

Promissory Note, Loan or Mortgage	Owner's Name	Transaction Date	Original Amount	Balance Due
Promissory Note			$	$
Loan			$	$
Mortgage			$	$

Did you and/or your spouse pay an entrance fee to enter a Continuing Care Retirement Community (CCRC) or Life Care Community (LCC)?

☐ **Yes, complete the section below.** ☐ **No**

Owner's Name	Transaction Date	Name and Address of CCR/LLC	Amount Paid
			$
			$

☐

SECTION 9 - OTHER CHANGES – Describe any other changes in the space below.

The Department may send you additional forms for additional information based on eligibility on a basis other than modified adjusted gross income (MAGI) and/or for long-term care. A change in information submitted by you could affect the eligibility for member(s) of your household. The Department of Human Services will obtain information to verify eligibility with electronic databases including but not limited to the Internal Revenue Service, Social Security Administration, Department of Homeland Security or a consumer reporting agency. If the information does not match, we may ask you to send us proof. **I certify the information that is provided on this Change of Circumstance Report form is true and to the best of my knowledge. If I intentionally make false statements on this form, I may be prosecuted under Hawaii Revised Statutes §710-1063. I give permission to the State of Hawaii to check my statements.**

Signature:	**Date:**

IF ANYONE IN YOUR HOUSEHOLD IS OVER 65 YEARS OLD, BLIND OR DISABLED, THE INDIVIDUAL AND THEIR SPOUSE AS APPLICABLE (i.e. adult tax dependents in your household) SIGN(S) BELOW

This authorization will end if my/our application for Medicaid is denied, or I am/we are no longer eligible for Medicaid, or I/we revoke this authorization in a written statement to my local Department of Human Services. SEC 1137(a) of the Act.

Additional Household Member(s) Signature(s):	Relationship to Applicant/Beneficiary	SSN	Date (mm/dd/yyyy)
	*SPOUSE		

DHS/MQD USE ONLY	COC COMPLETED IN KOLEA BY:	COMPLETED DATE: