STATE OF HAWAII
Department of Human Services

Med-QUEST Division

ADRC REFERRAL AND DETERMINATION/RE-DETERMINATION

PART I: REFERRAL TO ADRC — Completed ADRC Packet Received, Date ____/____/____

1. **APPLICANT/BENEFICIARY NAME** ______________________ **DATE OF BIRTH** ____/____/____
   CASE NO. ______________ **MQD BENEFICIARY I.D. NO.** ______________ **ELIG KEY CODE** _____
2. **TYPE OF REFERRAL:**
   - ☐ ADRC INITIAL DETERMINATION
   - ☐ ADRC REDETERMINATION, DATE LAST ADRC COMPLETED: ____/____/____ (attach a copy of last DHS 1180)
3. **REFERRAL SOURCE:**
   - ☐ MQD: ______________________________
     Section / Unit — Name of EW — Phone No. — Fax No.
   - ☐ HEALTH PLAN: ______________________________
     Name of Health Plan — Contact Person — Phone No. — Fax No.
4. ☐ DHS 1127
   - ☐ DHS 1128 ☐ HCFA 2728 submitted instead of DHS 1128
   - ☐ DHS 1147, SUB-ACUTE/LONG TERM CARE/HOSPICE LEVEL OF CARE EVALUATION, IF APPLICABLE, **AND**
   - ☐ ADDITIONAL INFORMATION OR SUPPORTING EVIDENCE FOR PHYSICAL or PSYCHIATRIC DISABILITY FROM THE HEALTH PLAN OR APPLICANT'S/BENEFICIARY'S MEDICAL PROVIDER.

   COMMENTS: ______________________________

PART II: DETERMINATION BY ADRC:

1. ☐ UNIT: ______________________ EW: ______________
   - ☐ HEALTH PLAN: ______________________ CONTACT: ______________
   - ☐ TREATING PHYSICIAN: ______________________________
2. **GAINFUL ACTIVITY DETERMINATION** (based on beneficiary's DHS 1127 statement, system verification of lack of income, other information sources, confirmed by MQD/CSO staff if needed)
   - ☐ GAINFUL ACTIVITY IS **NOT** POSSIBLE. ☐ GAINFUL ACTIVITY IS POSSIBLE

   COMMENTS: ______________________________

   CERTIFIED BY: ______________________________
   MQD/CSO Staff — Date
3. **ADRC DETERMINATION:**
   - ☐ NOT DISABLED
   - ☐ TEMPORARILY DISABLED TO: ____/____/____ (NOT ELIGIBLE FOR QExA)
   - ☐ DISABLED MORE THAN 12 MONTHS - MEETS SSI DISABILITY CRITERIA- MAKE REFERRAL to SSA
     - ☐ CONDITION REQUIRES RE-EVALUATION AFTER ONE YEAR ____/____/____
   - ☐ **EFFECTIVE DATE OF NEW HEALTH PLAN ENROLLMENT:** ____/____/____ ☐ UNABLE TO DETERMINE

   COMMENTS: ______________________________
   ____

   CERTIFIED BY: ______________________________
   Medical/Psychiatric Consultant — Date

PART III: PROGRAM ELIGIBILITY: To be completed by Eligibility Worker, if program change is required.

☐ Program changed ____/____/____ ☐ Not eligible for program change. Reason: ______________