STATE OF HAWAII
Department of Human Services

MED-QUEST Division

ASSIGNMENT OF PAYMENT,
REPAYMENT AGREEMENT, AND
AUTHORIZATION & WAIVER FOR RELEASE OF INFORMATION

I, _____ **FOR VALUE RECEIVED** hereby assign to the Department of Human Services (hereinafter referred to as DHS), and authorizes any of my representatives, agents, attorneys, or insurers, to pay to DHS, from any money due to me as compensation for injuries received in, and medical costs incurred as a result of an accident or incident on or about _____, a sum of money equal
Date of Accident or Incident

to that paid or to be paid by DHS, for any and all hospital, medical, and similar expenses necessitated by said accident or incident.

I HEREBY UNDERSTAND that completion of this Assignment is required by Federal and State law [42 U.S.C. SS 1396a(a)(25), 1396k(a); 42 CFR SS433.145, 433.148; S346-29, Hawaii Revised Statutes; and Chapter 17-1705, Hawaii Administrative Rules] as a condition of eligibility for medical assistance. I further understand that my failure or refusal to execute this Assignment shall cause my application to be denied and/or may lead to the termination of continued benefits.

I HEREBY FURTHER UNDERSTAND that this Assignment is in addition to my right of recovery, right of subrogation, or lien rights DHS may have to any proceeds from any judgment, award, settlement, or insurance proceeds for my injuries received as a result of the above-referenced accident or incident.

I HEREBY FURTHER AGREE to reimburse DHS, any and all medical costs paid on my behalf as a result of said accident or incident, should compensation be paid directly to me form any judgment, award, settlement or insurance proceeds for my injuries received as a result of the above-referenced accident or incident.

I HEREBY UNDERSTAND that this Repayment Agreement is in addition to any Assignment, right or recovery, right of subrogation, or lien rights DHS may have to any proceeds from any judgment, award, settlement, or insurance proceeds for my injuries received as a result of the above-referenced accident or incident.

I HEREBY AUTHORIZE any and all federal, state, and local government agencies and entities and any and all private entities of any kind or nature including but not limited to employers; insurance carriers; schools; law enforcement agencies and departments; physicians; hospitals; clinic; psychologists; dentists; social workers; counselors; therapists; and health care providers to furnish full and complete records, and information of nay nature or content as may be requested by DHS or the Department of the Attorney General.

I HEREBY WAIVE, if applicable, all requirements and provisions of the Federal Privacy Act (5 U.S.C. S552, 552(a) et seq.) and all other laws and regulations restricting the use and dissemination of the aforesaid information by, to, or at the direction of DHS or the State of Hawaii, Department of the Attorney General with the understanding that said information will be used as allowed by law for the purpose of establishing third party liability and obtaining third party reimbursements.

I HEREBY AGREE that a photocopy of the Assignment of Payment, Repayment Agreement, and Authorization and Waiver for Release of Information may serve as any original and shall not be canceled or made invalid without the express written consent of DHS or the State of Hawaii, Department of the Attorney General. Nothing contained herein shall act to preclude or limit the above-named recipient or their guardian or representative, from issuing other similar authorizations and waivers for release of information.

Date: _____, _____, t his _____of_____ 20__
City State Day Month Year

_____ _____
Signature of Witness Signature of Adult Recipient, Guardian or Representative

_____ _____
Printed Name of Witness Street Address

_____ _____
Title or Relationship of Witness City State Zip Code

THIS FORM WILL NOT BE ACCEPTED IF IT CONTAINS ANY

AMENDMENTS, ADDITIONS, ATTACHMENTS, OR CHANGES OF ANY NATURE

STATE OF HAWAII
Department of Human Services

Med-QUEST Division

SUPPLEMENT TO ASSIGNMENT OF PAYMENT – DHS 1125

SEPARATE FORMS MUST BE COMPLETED FOR EACH INDIVIDUAL INJURED IN ACCIDENT

(1) Name of Injured

Last Name First M.I.

(2) I.D. No. Case No.

(3) Date of Accident

Address

SSN

(4) Application Date

Case Name (if different from above)

Date of Birth Sex

Medical Elig. Date

(5) Type of Accident:

- ☐ Auto
- ☐ Bicycle
- ☐ Moped
- ☐ Worker's Compensation
- ☐ Motorcycle
- ☐ Assault
- ☐ Pedestrian
- ☐ Other: _____

(6) Medical Coverage

- ☐ HMSA-Medicaid
- ☐ QUEST Plan: _____
- ☐ Other(s) Hosp. & Med. Ins. _____

(7) Provide a brief but clear description of how the accident occurred. (Include actual time and location where accident occurred.)

(8) Describe the type of injury (e.g., broken arm, head injury, facial cuts or bruises, fracture of leg, etc. For additional space, use Sec. 18)

(9) Extent of injury (seriously, slightly, etc.)

(10) Recipient treated/seen by: (provide names of doctors, hospitals, laboratories, radiologists, pharmacists, dentists, etc.)

(11) Is recipient still under medical care for his/her injury? **YES**____ **NO**_____

(12) Person(s)/property owner(s) other than recipient who may be at Fault:

Their Insurance Co. and Policy No.:

(13) Does the recipient intend to file suit? **YES**____**NO**_____

(14) Date of settlement (if applicable)

(15) Name, address, and telephone number of recipient's attorney(s):

(16) Recipient had at the time of accident:

- ☐ Free No-Fault Ins. **(Attach copy of HJUP-8 Certificate of Eligibility)**
- ☐ Purchased No-Fault Ins.
- ☐ No Coverage

Name of Insurance Co., Policy No. and Claim No.

(17) Recipient was injured in own vehicle as a:

- ☐ Driver or
- ☐ Passenger

Recipient was injured in/by another vehicle as a:

- ☐ Driver of borrowed car
- ☐ Passenger
- ☐ Pedestrian
- ☐ Other (Please explain in Sec. 17)

Name of vehicle owner and Insurance Co. and Policy No.

Name of driver of vehicle and Insurance Co. and Policy No. (if different from above)

(18) Other information (use blank sheet if additional space is needed

(19 Worker's Name
(22) Phone No.

(20) Date

(21) Section/Unit