KAISER PERMANENTE®

Kaiser Permanente Subsidy Eligibility Form – 2017

The Kaiser Permanente subsidy is offered as part of Kaiser Permanente's Child Health Program to help pay your monthly premiums and most out-of-pocket medical costs under the Kaiser Permanente Platinum 90 - HMO plan.

Eligibility for the Kaiser Permanente Child Health Program will be considered for individuals who are uninsured and:

- Live in the Kaiser Foundation Health Plan, Inc., service area
- Are under 19 years of age at the time of the effective date of the Kaiser Permanente plan
- Live in a household with incomes up to 300% of the federal poverty level (for example, $35,640 for an individual and $72,900 for a family of 4, per 2016 guidelines)
- Are not eligible for financial assistance through Covered California and do not have access to any other public or private health coverage, including, but not limited to, Medi-Cal, Medicare, or a job-based health plan. Children under 19 years of age living in households with income at or below 266% of the federal poverty level are eligible for Medi-Cal.

Even if you have an affordability exemption from the federal government, you must still meet all the eligibility criteria listed above to be approved for Kaiser Permanente's Child Health Program. U.S. citizenship is not an eligibility requirement.

Enrollment in Kaiser Permanente's Child Health Program is available during the Individuals and Families annual open enrollment and special enrollment periods. In general, the special enrollment period lasts for 60 days after a triggering event, such as marriage, birth or adoption of a child, divorce, or loss of job and job-based health coverage. Enrollment into this charitable, subsidized program is limited and subject to availability.

How to apply for Kaiser Permanente's Child Health Program

Step 1

Complete 2 separate documents:

- **For health coverage –** complete the Kaiser Permanente for Individuals and Families application.
- **For the Kaiser Permanente subsidy –** complete this form for all applicants in your household.

Please complete the Kaiser Permanente for Individuals and Families application before you complete the Kaiser Permanente Subsidy Eligibility Form.

Step 2

Include the following documents:

Proof of your most current household's gross income:

- If employer paid – include your last 3 paycheck stubs, W-2 forms, or wage and/or tax statements.
- If self-employed – include Schedule C and page 1 (the adjusted gross income page) of last year's federal income tax return or a profit and loss form.
- If paid in cash – include a signed letter of income from your employer.

Please note: The information including, but not limited to, name, income, and address, that you provide on this form will be used or disclosed by Kaiser Permanente to determine your eligibility for Kaiser Permanente's subsidy and your eligibility for other health care or social service programs, or for any other purpose required by law.

If you apply for a Kaiser Permanente subsidy through a community organization, that organization may use your information to determine your eligibility for another health care or social service program, or for any other purpose required by law.

If you receive income from other sources (for example, Social Security, unemployment benefits, etc.), please include a copy showing proof. If you have received an affordability exemption from the federal government, documentation is required.

Proof of your most current household's income deductions:

- If student loan interest – include your last student loan statement
- If alimony paid – include a copy of your check
- If self-employed – include all receipts

How to complete and submit the forms for the Child Health Program

- Use only black or blue ink to complete the forms.
- Check that you have:
  - Answered all questions completely and provided proof of current income and income deductions
  - Signed both forms
  - Provided proof of guardianship (if applicable)
  - Made a copy for your records
- Mail the completed Kaiser Permanente for Individuals and Families application, Kaiser Permanente Subsidy Eligibility Form, and proof of current income and income deductions to:

  Charitable Health Coverage Operations
  P.O. Box 12904
  Oakland, CA 94604-9923
  Fax: **866-874-1793**

Please note, failure to submit documentation may delay the processing of your application. We are here to help you. If you have any questions about the forms for the Child Health Program, please call us toll free at **800-255-5053,** Monday, Wednesday, Thursday, and Friday from 8 a.m. to 4 p.m. Pacific time (PT) and Tuesday from 12:30 to 4 p.m. PT.

Frequently asked questions

1. **How long does it take to determine eligibility for Kaiser Permanente's Child Health Program?**

   Completed forms can take up to 30 business days to process as long as all required documentation is included. Completion of this form does not guarantee enrollment in Kaiser Permanente's Child Health Program.

2. **What if I'm not accepted for the Child Health Program?**

   If you are not accepted and still want to purchase a Kaiser Permanente Individuals and Families plan on your own, please call our National Direct Sales Center at **866-329-3468** or visit **buykp.org**.

3. **How much will I pay each month for the Kaiser Permanente Child Health Program?**

   There is no monthly payment required. Kaiser Permanente will subsidize the full monthly premium.

4. **What happens when I no longer meet the eligibility requirements for the Child Health Program?**

   When you no longer meet our eligibility requirements, you will be disenrolled from Kaiser Permanente's Child Health Program, which includes the Kaiser Permanente subsidy and medical financial assistance. You will remain enrolled in the Platinum 90 - HMO plan, but you will be responsible for paying the full monthly premium and any out-of-pocket costs until you ask us to terminate your membership or until you fail to pay the full premium.

SECTION 1: Parent or legal guardian (if applicable)

Parent or legal guardian (if applicable)

Only complete this section if you are a parent or guardian applying for a child under 18.

First name MI

Last name

Mailing address (P.O. box acceptable)

City State ZIP code Phone

SECTION 2: Applicant information

Primary applicant

Is the person who will be covered by the health plan and requesting the Child Health Program subsidy. The primary applicant must reside in our service area. If applying for a child under 18, the parent or guardian should provide the child's information below.

First name MI

Last name

Date of birth (mm/dd/yyyy) Gender: ☐ Male ☐ Female Kaiser Permanente medical record number (if available):

Mailing address (no P.O. boxes, please)

City State ZIP code Phone

Preferred language spoken (if not English)

Employment status (if applicable): ☐ Full-time ☐ Part-time ☐ Unemployed ☐ Self-employed ☐ Retired ☐ Disabled ☐ Student ☐ Other

Pay amount and frequency: ☐ Daily ☐ Weekly ☐ Monthly ☐ Biweekly ☐ Semi-monthly ☐ Other _____

Pay source: ☐ Wages ☐ Self-employment ☐ Pension ☐ Student ☐ Other

Please answer the following questions about the primary applicant.
Is the primary applicant who will be covered by the health plan …

A U.S. citizen?	☐ Yes ☐ No
A legal permanent resident?	☐ Yes ☐ No
If Yes, how many years has the primary applicant been a legal permanent resident?	
Eligible for health coverage through public programs such as **Medi-Cal?**	☐ Yes ☐ No
Eligible for financial assistance through **Covered California?**	☐ Yes ☐ No
Currently receiving or have access to a job-based health plan or another health plan?	☐ Yes ☐ No

SECTION 3: Family information

Family member 1

Please complete this section for each additional family member. If the family member is under 18, the parent/guardian should complete this section for the applicant.

Please select one of the following: ☐ Parent/Guardian ☐ Spouse/Domestic Partner ☐ Dependent

First name MI

Last name

Date of birth (mm/dd/yyyy)

Gender: ☐ Male ☐ Female

Kaiser Permanente medical record number (if available):

Preferred language spoken (if not English)

Employment status (if applicable): ☐ Full-time ☐ Part-time ☐ Unemployed ☐ Self-employed ☐ Retired ☐ Disabled ☐ Student ☐ Other _____

Pay amount and frequency: ☐ Daily ☐ Weekly ☐ Monthly ☐ Biweekly ☐ Semi-monthly ☐ Other

Pay source: ☐ Wages ☐ Self-employment ☐ Pension ☐ Student ☐ Other _____

Please answer the following questions if family member 1 is applying for the health plan. Is family member 1 …

A U.S. citizen?	☐ Yes ☐ No
A legal permanent resident?	☐ Yes ☐ No
If Yes, how many years has the family member been a legal permanent resident?	
Eligible for health coverage through public programs such as **Medi-Cal?**	☐ Yes ☐ No
Eligible for financial assistance through **Covered California?**	☐ Yes ☐ No
Currently receiving or have access to a job-based health plan or another health plan?	☐ Yes ☐ No

SECTION 3: Family information *(continued)*

Family member 2

Please complete this section for each additional family member. If the family member is under 18, the parent/guardian should complete this section for the applicant.

Please select one of the following: ☐ Parent/Guardian ☐ Spouse/Domestic Partner ☐ Dependent

First name MI

Last name

Date of birth (mm/dd/yyyy)

Gender: ☐ Male ☐ Female

Kaiser Permanente medical record number (if available):

Preferred language spoken (if not English)

Employment status (if applicable): ☐ Full-time ☐ Part-time ☐ Unemployed ☐ Self-employed ☐ Retired ☐ Disabled ☐ Student ☐ Other

Pay amount and frequency: ☐ Daily ☐ Weekly ☐ Monthly ☐ Biweekly ☐ Semi-monthly ☐ Other

Pay source: ☐ Wages ☐ Self-employment ☐ Pension ☐ Student ☐ Other

Please answer the following questions if family member 2 is applying for the health plan. Is family member 2 …

A U.S. citizen?	☐ Yes ☐ No
A legal permanent resident?	☐ Yes ☐ No
If Yes, how many years has the family member been a legal permanent resident?	
Eligible for health coverage through public programs such as **Medi-Cal?**	☐ Yes ☐ No
Eligible for financial assistance through **Covered California?**	☐ Yes ☐ No
Currently receiving or have access to a job-based health plan or another health plan?	☐ Yes ☐ No

SECTION 3: Family information *(continued)*

Family member 3

Please complete this section for each additional family member. If the family member is under 18, the parent/guardian should complete this section for the applicant.

Please select one of the following: ☐ Parent/Guardian ☐ Spouse/Domestic Partner ☐ Dependent

First name MI

Last name

Date of birth (mm/dd/yyyy)

Gender: ☐ Male ☐ Female

Kaiser Permanente medical record number (if available):

Preferred language spoken (if not English)

Employment status (if applicable): ☐ Full-time ☐ Part-time ☐ Unemployed ☐ Self-employed ☐ Retired ☐ Disabled ☐ Student ☐ Other

Pay amount and frequency: ☐ Daily ☐ Weekly ☐ Monthly ☐ Biweekly ☐ Semi-monthly ☐ Other

Pay source: ☐ Wages ☐ Self-employment ☐ Pension ☐ Student ☐ Other

Please answer the following questions if family member 3 is applying for the health plan. Is family member 3 …

A U.S. citizen?	☐ Yes ☐ No
A legal permanent resident?	☐ Yes ☐ No
If Yes, how many years has the family member been a legal permanent resident?	
Eligible for health coverage through public programs such as **Medi-Cal?**	☐ Yes ☐ No
Eligible for financial assistance through **Covered California?**	☐ Yes ☐ No
Currently receiving or have access to a job-based health plan or another health plan?	☐ Yes ☐ No

SECTION 3: Family information *(continued)*

Family member 4

Please complete this section for each additional family member. If the family member is under 18, the parent/guardian should complete this section for the applicant.

Please select one of the following: ☐ Parent/Guardian ☐ Spouse/Domestic Partner ☐ Dependent

First name MI

Last name

Date of birth (mm/dd/yyyy)

Gender: ☐ Male ☐ Female

Kaiser Permanente medical record number (if available):

Preferred language spoken (if not English)

Employment status (if applicable): ☐ Full-time ☐ Part-time ☐ Unemployed ☐ Self-employed ☐ Retired ☐ Disabled ☐ Student ☐ Other

Pay amount and frequency: ☐ Daily ☐ Weekly ☐ Monthly ☐ Biweekly ☐ Semi-monthly ☐ Other

Pay source: ☐ Wages ☐ Self-employment ☐ Pension ☐ Student ☐ Other

Please answer the following questions if family member 4 is applying for the health plan. Is family member 4 …

A U.S. citizen?	☐ Yes ☐ No
A legal permanent resident?	☐ Yes ☐ No
If Yes, how many years has the family member been a legal permanent resident?	
Eligible for health coverage through public programs such as **Medi-Cal?**	☐ Yes ☐ No
Eligible for financial assistance through **Covered California?**	☐ Yes ☐ No
Currently receiving or have access to a job-based health plan or another health plan?	☐ Yes ☐ No

SECTION 3: Family information *(continued)*

Family member 5

Please complete this section for each additional family member. If the family member is under 18, the parent/guardian should complete this section for the applicant.

Please select one of the following: ☐ Parent/Guardian ☐ Spouse/Domestic Partner ☐ Dependent

First name MI

Last name

Date of birth (mm/dd/yyyy)

Gender: ☐ Male ☐ Female

Kaiser Permanente medical record number (if available):

Preferred language spoken (if not English)

Employment status (if applicable): ☐ Full-time ☐ Part-time ☐ Unemployed ☐ Self-employed ☐ Retired ☐ Disabled ☐ Student ☐ Other

Pay amount and frequency: ☐ Daily ☐ Weekly ☐ Monthly ☐ Biweekly ☐ Semi-monthly ☐ Other

Pay source: ☐ Wages ☐ Self-employment ☐ Pension ☐ Student ☐ Other

Please answer the following questions if family member 5 is applying for the health plan. Is family member 5 …

A U.S. citizen?	☐ Yes ☐ No
A legal permanent resident?	☐ Yes ☐ No
If Yes, how many years has the family member been a legal permanent resident?	
Eligible for health coverage through public programs such as **Medi-Cal?**	☐ Yes ☐ No
Eligible for financial assistance through **Covered California?**	☐ Yes ☐ No
Currently receiving or have access to a job-based health plan or another health plan?	☐ Yes ☐ No

If you have additional family members, please photocopy this page and provide the same information requested above for each additional member.

SECTION 4: Household income

What is the total number of people in your household, including yourself?

Please list your **total** household gross income for the last calendar month in the chart below. Be sure to include income from all the people you listed in the previous section, including yourself, **and** any additional people that contribute to your household income even if they aren't applying for the Child Health Program. If an item does not apply, write "N/A" (not applicable).

Attach copies of the most current proof of income for all the items included below (examples: pay stubs; award letters for Social Security, or unemployment benefits; a 1040 from previous tax year; W-2 from current employer; letter from employer; or a bank statement).

Total household gross income (for the last calendar month)			
Gross income from wages, tips	$	Disability insurance	$
Social Security benefits	$	Veterans' benefits	$
Support or gifts from family/friends	$	Pension/retirement income	$
Spousal/child support	$	Rental income you receive from property you own and lease	$
Unemployment benefits	$	Interest income	$
Workers' compensation	$	Student financial aid	$
		Other income	$

Does anyone in your household have any income deductions? ☐ Yes ☐ No

These deductions might help you qualify for the Kaiser Permanente subsidy. Please attach copies of the most current proof of deductions for the items listed below:

Total income deductions (for the last calendar month)			
Type of deduction	**Who receives the deduction**	**Amount paid**	**Frequency of payment**
Student loan interest			
Alimony paid			
Self-employed expenses			
Other: Please specify			

Self-employment: If any member of your household is self-employed, please submit a copy of Schedule C and page 1 (the adjusted gross income page) of last year's federal income tax return or a profit and loss form for each business.

SECTION 5: Certification

By signing this form, you certify the information on this form is correct and accurate. If you provide any incorrect or incomplete information on this form or in further correspondence concerning this form, any Kaiser Permanente subsidy to cover costs related to health coverage may be terminated. Membership approval for Kaiser Permanente's Child Health Program is not guaranteed as it is based on eligibility and availability.

X _____ Date (mm/dd/yyyy)

Signature (primary applicant or financially responsible party, parent or legal guardian for applicants under 18)

Your representative

You can choose a community partner/agency representative, relative, or friend to act for you on matters related to this form, including getting information about this form and signing the form for you. If you ever need to change your representative, contact us.

Name of authorized representative (please be sure to provide the name of the same authorized representative you listed on the Kaiser Permanente for Individuals and Families application):

First name MI

Last name

Organization name (if applicable) Kaiser Permanente entity enrollment number (if applicable)

Address (no P.O. boxes, please)

City State ZIP code Phone

Signature to authorize the representative (listed above) to sign the Kaiser Permanente Subsidy Eligibility Form, get official information about this form, and act for you on all future matters regarding this form.

X _____ Date (mm/dd/yyyy)

Signature (primary applicant or financially responsible party, parent or legal guardian for applicants under 18)