KAISER PERMANENTE®

Community Health Care Program Application for subsidy – 2024

Use this form to apply for a subsidy to pay your monthly premiums and most out-of-pocket costs under the Kaiser Permanente Platinum 90 HMO plan. There is no cost to apply.

Enrollment in Kaiser Permanente's Community Health Care Program is available during the Individuals and Families annual open enrollment and special enrollment periods. The special enrollment period generally lasts 60 days from the date of your qualifying life event. Some qualifying life events allow more than 60 days from the date of your qualifying life event. Visit **kp.org/chcspecialenrollment** for more information. To apply, follow these steps:

Step 1: Fill out the Application for subsidy form

- Type or print using black or blue ink.
- Answer all questions completely.
- Sign the form.
- Make a copy of the completed form for your records.

Step 2: Fill out the separate Kaiser Permanente Application for health coverage.

Step 3: Include proof of income

Attach copies of the most current proof of your household's gross income:

- If employer paid – include your last 2 paycheck stubs, W-2, or pay 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.
- 1040 tax form from previous year – if you submit your 1040 tax form, no other proof of income is required.
- See Section 4 for more examples of proof of income.

If your household has income deductions, provide proof such as:

- Student loan interest – include your last student loan statement.
- Self-employed – Schedule C and page 1 (the adjusted gross income page) of last year's federal income tax return or a profit and loss form.

Eligibility rules:

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

- Live in the Kaiser Foundation Health Plan, Inc. California service area
- Live in a household with an income up to 300% of the federal poverty level
- Can't be eligible for other public or private health coverage such as, but not limited to Medi-Cal, Medicare, a job-based health plan, or financial help through Covered California. Children younger than 19 living in households with an income at or below 266% of the federal poverty level are eligible for Medi-Cal. Adults with an income of up to 138% of the federal poverty level are also eligible for Medi-Cal.

Please apply to Medi-Cal first before applying for CHCP.

You do NOT have to be a U.S. citizen to be eligible for Kaiser Permanente's Community Health Care Program.

Step 4: Include additional documents

- Medi-Cal and/or Covered California denial letters if applicable.
- Provide proof of guardianship if applicable.
- Other information or documentation that may help us evaluate your eligibility.

Step 5: Send your forms, proof of income, and all other required documents

Send your completed and signed **Application for subsidy,** Application for health coverage, proof of current income, income deductions, and other required documents through one of the following options:

- By email:
  CHC-Applications@kp.org
  (Include "application" in the subject line)
- By mail:
  Kaiser Permanente
  Attn: CHC
  P.O. Box 23127
  San Diego, CA 92193-3127
- By fax:
  1-855-355-5334

We're here to help:

If you have questions about the Community Health Care Program or about this form, please call us at:

1-800-464-4000 (TTY **711**)

24 hours a day, 7 days a week

(closed major holidays)

Please note: Continued eligibility for the Community Health Care Program is not guaranteed. We reserve the right to close enrollment or change the eligibility rules at any time. If you are approved for the subsidy, the subsidy period is limited and we will contact you in the future to confirm that you still qualify.

Kaiser Permanente will keep your information private, as required by law, and use your personal information only to see if you qualify for Kaiser Permanente's subsidy.

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 other purpose required by law.

Frequently asked questions

1. **How long does it take to find out if I am approved or denied for Kaiser Permanente's Community Health Care Program?**
   Completed forms that include all required documentation can take up to 6 weeks to process. If information is missing, it may take longer and you may miss the deadline for applying. Completion of this form does not guarantee enrollment in Kaiser Permanente's Community Health Care Program.

2. **How much will I pay each month for the Kaiser Permanente Community Health Care Program?**
   No monthly payment is required. Kaiser Permanente will subsidize the full monthly premium.

3. **What happens when I no longer meet the eligibility requirements?**
   When you no longer meet our eligibility requirements, you will be disenrolled from Kaiser Permanente's Community Health Care Program. You will remain enrolled in the Platinum 90 HMO plan, but you'll have to pay your full monthly premiums and out-of-pocket costs, unless you ask us to end your membership or until you fail to pay the full premium.

4. **I can't afford to pay for coverage through Covered California. Can I still qualify for the Community Health Care Program?**
   Not being able to pay Covered California premiums does not qualify you for the Community Health Care Program. You must meet the Community Health Care Program income and other criteria to qualify.

5. **What other health coverage programs are available?**
   Medi-Cal has expanded to all low-income adults. Apply to Medi-Cal before applying for CHCP. Children younger than 19 living in households with income at or below 266% of the federal poverty level ($38,783 for an individual or $79,800 for a family of 4 in 2023) are eligible for Medi-Cal. If you are 19 or older, you may be eligible if your household income is at or below 138% of the federal poverty level ($20,1200 for an individual or $41,400 for a family of 4 in 2023). Kaiser Permanente is a Medi-Cal provider and may be available to you. For more information, visit kp.org/medi-cal or call the Kaiser Permanente Medicaid Assistance Center at **1-800-557-4515** (TTY **711**). You may also contact a community organization or your local county services office for more information.

   Buy health care coverage through Covered California. If you qualify, you may get help paying for your plan premiums or out-of-pocket costs. Remember to enroll during the Covered California open enrollment period. If you wait until after the open enrollment period ends, you'll need a qualifying life event to enroll in a new plan. For more information, visit CoveredCA.com, which also has Kaiser Permanente plans.

   Call us at 1-800-488-3590 (TTY 711) or visit **buykp.org** to learn about other Kaiser Permanente for Individuals and Families plan choices.

   Consider Medicare, a federal program available to people ages 65 or older. There are different periods in which you may be eligible to enroll in a Medicare health plan. Visit **kp.org/medicare** for more information. If you have limited household income, you may qualify for Medi-Cal. Please visit **kp.org/medi-cal** to learn more.

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Frequently asked questions *(continued)*

6. Is the Community Health Care Program a public benefit that could impact my ability to become a lawful permanent resident or U.S. citizen in the future?
No, the Community Health Care Program is not a public benefit. It is a Kaiser Permanente sponsored program to help pay for health coverage for low-income families and individuals that don't have access to public/private health coverage.

7. What if I'm not accepted into the Community Health Care Program?
If you're not accepted, there may be other health coverage programs available to you. See question 5 for more information.

SECTION 1: Applicant information (Required)

Primary applicant

The person who will be covered by the health plan and applying for the Community Health Care Program subsidy. If applying for a child under 18, the parent or legal guardian should provide the child's information below. The parent or legal guardian information should be filled out in Section 2.

First name*

MI

Last name*

Date of birth* (mm/dd/yyyy)

Medical record number (if available)

Gender*
☐ Male ☐ Female ☐ Undeclared

Home phone

Mobile phone

Home address* (Include Apt. Number. No P. O. boxes, please)

City*

State*

ZIP code*

Mailing address (If different than home address. Include apt. number.)

City

State

ZIP code

Email

Please answer **ALL** applicable questions below about the primary applicant. This information is only used to find out if the primary applicant is eligible for the Community Health Care Program or other programs that provide health coverage.

Is the primary applicant…

Offered health coverage through an employer?* ☐ **Yes** ☐ **No**

A U.S. citizen?* ☐ **Yes** ☐ **No**
If you answered yes, skip the following two questions.

A Lawful Permanent Resident[1]? ☐ **Yes** ☐ **No**

If yes, how many years have they been a Lawful Permanent Resident[1]? _____

*Indicates a required field

1. A Lawful Permanent Resident (LPR) is not a U.S. citizen. An LPR is an immigrant who resides in the U.S. under a legally recognized permanent residence status. Examples include Green Card Holders, Permanent Resident Aliens, and Resident Alien Permit Holders.

SECTION 2: Parent or legal guardian (if applicable)

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

First name

MI

Last name

Date of birth (mm/dd/yyyy)

Gender
☐ Male ☐ Female ☐ Undeclared

Home phone

Mobile phone

Mailing address (Include Apt. Number. P. O. boxes acceptable)

City

State

ZIP code

Email

SECTION 3: Family information (if applicable)

Spouse/domestic partner to be covered (if applicable)

Please complete this section for the spouse/domestic partner who will be covered by the health plan and applying for the Community Health Care Program subsidy. If an applicant is under 18, the parent or legal guardian should complete this section for the applicant.

First name

MI

Choose one:
☐ Spouse ☐ Domestic partner

Last name

Date of birth (mm/dd/yyyy)

Medical record number (if available)

Gender
☐ Male ☐ Female ☐ Undeclared

Please answer **ALL** applicable questions below about the spouse/domestic partner. This information is only used to find out if the spouse/domestic partner is eligible for the Community Health Care Program or other programs that provide health coverage.

Is the spouse/domestic partner …

Offered health coverage through an employer?* ☐ **Yes** ☐ **No**

A U.S. citizen? ☐ **Yes** ☐ **No**
If you answered yes, skip the following two questions.

A Lawful Permanent Resident[1]? ☐ **Yes** ☐ **No**

If yes, how many years have they been a Lawful Permanent Resident[1]? _____

(continues)

1. A Lawful Permanent Resident (LPR) is not a U.S. citizen. An LPR is an immigrant who resides in the U.S. under a legally recognized permanent residence status. Examples include Green Card Holders, Permanent Resident Aliens, and Resident Alien Permit Holders.

SECTION 3: Family information *(continued)*

Dependent 1 to be covered

Please complete this section for each additional dependent who will be covered by the health plan and applying for the Community Health Care Program subsidy. If an applicant is under 18, the parent or legal guardian should complete this section for the applicant. If you have more than 3 dependents applying, please copy this page and fill out the same information requested below for each additional dependent.

First name

MI

Last name

Date of birth (mm/dd/yyyy)

Medical record number (if available)

Gender
☐ Male ☐ Female ☐ Undeclared

Relationship to primary applicant

Please answer **ALL** applicable questions below about the dependent. This information is only used to find out if the dependent is eligible for the Community Health Care Program or other programs that provide health coverage.

Is the dependent …

Offered health coverage through an employer?* ☐ **Yes** ☐ **No**

A U.S. citizen? ☐ **Yes** ☐ **No**
If you answered yes, skip the following two questions.

A Lawful Permanent Resident[1]? ☐ **Yes** ☐ **No**

If yes, how many years have they been a Lawful Permanent Resident[1]? _____

(continues)

1. A Lawful Permanent Resident (LPR) is not a U.S. citizen. An LPR is an immigrant who resides in the U.S. under a legally recognized permanent residence status. Examples include Green Card Holders, Permanent Resident Aliens, and Resident Alien Permit Holders.

SECTION 3: Family information *(continued)*

Dependent 2 to be covered

Please complete this section for each additional dependent who will be covered by the health plan and applying for the Community Health Care Program subsidy. If an applicant is under 18, the parent or legal guardian should complete this section for the applicant.

First name

MI

Last name

Date of birth (mm/dd/yyyy) / /

Medical record number (if available)

Gender
☐ Male ☐ Female ☐ Undeclared

Relationship to primary applicant

Please answer **ALL** applicable questions below about the dependent. This information is only used to find out if the dependent is eligible for the Community Health Care Program or other programs that provide health coverage.

Is the dependent …

Offered health coverage through an employer?* ☐ **Yes** ☐ **No**

A U.S. citizen?
If you answered yes, skip the following two questions. ☐ **Yes** ☐ **No**

A Lawful Permanent Resident[1]? ☐ **Yes** ☐ **No**

If yes, how many years have they been a Lawful Permanent Resident[1]? _____

Dependent 3 to be covered

Please complete this section for each additional dependent who will be covered by the health plan and applying for the Community Health Care Program subsidy. If an applicant is under 18, the parent or legal guardian should complete this section for the applicant.

First name

MI

Last name

Date of birth (mm/dd/yyyy) / /

Medical record number (if available)

Gender
☐ Male ☐ Female ☐ Undeclared

Relationship to primary applicant

Please answer **ALL** applicable questions below about the dependent. This information is only used to find out if the dependent is eligible for the Community Health Care Program or other programs that provide health coverage.

Is the dependent …

Offered health coverage through an employer?* ☐ **Yes** ☐ **No**

A U.S. citizen?
If you answered yes, skip the following two questions. ☐ **Yes** ☐ **No**

A Lawful Permanent Resident[1]? ☐ **Yes** ☐ **No**

If yes, how many years have they been a Lawful Permanent Resident[1]? _____

1. A Lawful Permanent Resident (LPR) is not a U.S. citizen. An LPR is an immigrant who resides in the U.S. under a legally recognized permanent residence status. Examples include Green Card Holders, Permanent Resident Aliens, and Resident Alien Permit Holders.

SECTION 4: Household income (Required)

Your family size and household income help us determine if you are eligible for the Community Health Care Program.

(A) What is the total number of family members† in your household?* _____

†If you file taxes, this is the same number of family members that you report on your tax form. (You do not need to file taxes to apply.) Usually, this includes yourself and the immediate family members who live with you such as your spouse and your children 18 and under (up to 23 if a student).

(B) How many of the family members counted in (A) contribute to your household/family income?* _____

(C) Please complete the table below.

- List the estimated yearly gross income (before taxes) for each family member counted in (B).
- If (B) is more than 3, make a copy of this page, provide the same information for each additional family member, and send it with your application.
- For child dependents who are working but whose income is below the threshold required for filing taxes ($12,950 in 2022):
  - Do not include them in the number of family members who contribute to household/family income
  - Do not include their income in the chart below
  - Do not submit proof of income documents

Estimated yearly income (before taxes)	family member 1	family member 2	family member 3
Income from wages, tips, and self-employment income	$	$	$
Social Security Disability (SSDI) payments	$	$	$
Unemployment benefits	$	$	$
Pension/retirement income	$	$	$
Rental income you get from property you own and lease	$	$	$
Interest income and annuities	$	$	$
Student financial aid – only include if used for living expenses (scholarships, awards, grants for tuition/education expenses are not counted as income)	$	$	$
Alimony received (for settlements before 2019)	$	$	$
Other income, such as capital gains, clergy earnings, or gambling income	$	$	$
TOTAL INCOME	$ *	$	$

Attach copies of the most current proof of income for the items you include in the table above.
Examples include:

- Pay stubs
- Award letters for Social Security or unemployment benefits
- 1040 tax form from previous year
- W-2 from current employer
- Letter from employer

We will calculate your total yearly household income by adding up the amounts shown in your submitted proof of income documents. If you submitted your 1040 tax form, no other proof of income is required. If your proof of income documents don't match the yearly gross income in the table above, please explain any special circumstances that we should consider when we are reviewing your income documents:

☐ Only myself/my spouse works ☐ Hours have been cut or are not consistent ☐ Recent job change
☐ I do not work ☐ Self employed ☐ Other (please explain) _____

(continues)

*Indicates a required field

SECTION 4: Household income *(continued)*

If any family member included in table (C) has income deductions, please complete the table below.

Estimated yearly income deductions	family member 1	family member 2	family member 3
Student loan interest	$	$	$
Self-employed expenses	$	$	$
Alimony paid (for settlements before 2019)	$	$	$
Other deductions: Please specify	$	$	$
TOTAL DEDUCTIONS	$	$	$

Attach copies of the most current proof of deductions for the items listed above (examples: student loan statement, self-employment receipts). **We will calculate the total deductions by adding up the proof of deductions documents. If your proof of deductions doesn't match the total deductions in the above table, please explain in the space provided on page 9.**

Self-employment: If any family member included in table (C) is self-employed, 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: Choose an authorized representative (if you have one)

You can give a community partner/agency, representative, relative, or trusted friend permission to talk about this form with us, see your information, or act for you on matters related to this form only. This person or community partner/agency is called an authorized representative.

First name

MI

Last name

Organization name (if applicable)

Kaiser Permanente entity enrollment number (if applicable)

Phone

By signing, you've appointed this person or community partner/agency as your legally authorized representative to get information for this Kaiser Permanente form and to act for you on matters related to this form. This authorization lasts until December 31, 2025 or until you cancel it. You may cancel the authorization at any time by submitting a signed written request to Kaiser Permanente, Attn: CHC, P.O. Box 23127, San Diego, CA 92193-3127 or fax: 1-855-355-5334. Once you cancel, we will stop sharing your information and no longer use it, except to the extent that the information has been relied upon before. Once we disclose to your representative, your information may be redisclosed by your representative and no longer protected by federal privacy law. Even if you don't sign this authorization, we will still process your application for the Community Health Care Program subsidy but we will not be able to share your information with your representative. You have a right to receive a copy of this authorization.

X

Date (mm/dd/yyyy)

Required signature (primary member or financially responsible party, parent or legal guardian for members under 18)

SECTION 6: Sign the application agreement (Required)

By signing this form, you certify the information on this form is correct and accurate. If you provide 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 Community Health Care Program is not guaranteed as it is based on eligibility and availability.

X

Date (mm/dd/yyyy)

Required signature (primary member or financially responsible party, parent or legal guardian for members under 18)

All plans are offered and underwritten by Kaiser Foundation Health Plan Inc., One Kaiser Plaza, Oakland, CA 94612.