KAISER PERMANENTE®

Community Health Coverage Program (CHCP) Reapplication for subsidy – 2027

Use this form to reapply for a subsidy to pay your monthly premiums and most out-of-pocket costs under your Kaiser Permanente plan. There is no cost to reapply. To reapply, follow these steps:

Step 1: Reapply by the deadline

To reapply for CHCP, we must receive this form by **October 1, 2026**. If we do not receive your form by this date, you'll no longer be eligible for CHCP and you'll have to pay the full monthly premium and out of pocket costs, starting January 1, 2027.

You can now reapply online! Visit kp.org/ca-chcp/members or scan the QR code to get started.

Step 2: Fill out the Reapplication for subsidy form

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

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 1040 tax form from previous year. Please note: if tax form is submitted, no other proof of income is required.
- 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 indicating gross income and pay frequency from your employer.
- 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 CHCP 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.
- Not eligible for other public or private health coverage such as, but not limited to Medi-Cal, Medicare, an affordable job-based health plan, or financial help through Covered California.
- In most cases, child dependents must be younger than 26.
- Individuals over 21 are eligible to receive the CHCP subsidy for a maximum of 3 years in a row. Eligible dependents can continue to receive the subsidy until they turn 21, no matter how long they've been in the program.
- The CHCP subsidy is available as a one-time resource, and all members must reapply annually. Members who do not reapply in consecutive years will lose future eligibility.

Step 4: Include additional documents

- Provide proof of guardianship if applicable.
- Other information or documentation that may help us evaluate your eligibility.

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

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

- Online (preferred): **kp.org/ca-chcp/members**
- By email: **CHC-Applications@kp.org**
  (Include "application" in the subject line)
- By mail: Kaiser Permanente
  Attn: CHC
  P.O. Box 939095
  San Diego, CA 92193-9095
- By fax: **1-855-355-5334**

We're here to help:

If you have questions about the Kaiser Permanente Community Health Coverage Program (CHCP) or about this form, please call us at:

1-800-464-4000 (TTY 711)

24 hours a day, 7 days a week (except holidays).

Community Partner information

Please contact a participating community partner with questions. Visit **kp.org/ca-chcp/gethelp** to find a participating community partner near you.

When you'll hear from us: Submitted applications are processed in order of receipt. We'll let you know if you've been approved for CHCP after we receive and review your completed forms and any proof of income.

Please note: Continued eligibility for CHCP isn't guaranteed. We reserve the right to close enrollment or change the eligibility rules at any time. If you're approved for the subsidy, the subsidy period is limited and we'll 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 purposes required by law.

Frequently asked questions

1. How long does it take to find out if I am approved or denied for the Kaiser Permanente Community Health Coverage Program (CHCP)?

Submitted applications are processed in order of receipt. We'll let you know if you've been approved for CHCP after we receive and review your completed forms and any proof of income.

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 reapplying. Completion of this form does not guarantee enrollment in CHCP.

2. How much will I pay each month for CHCP?

No monthly payment is required. Kaiser Permanente will pay the full monthly premium and out-of-pocket costs for items and services received at Kaiser Permanente facilities.

3. What happens when I no longer qualify?

When you no longer qualify, you will no longer receive our CHCP subsidy for premiums and out-of-pocket costs. You will remain enrolled in the Kaiser Permanente - Platinum 90 HMO plan, **but you'll have to pay your full monthly premiums and out-of-pocket costs,** unless you ask us to disenroll you or until you fail to pay the full premium. See Section 6 for your options.

4. What is the CHCP subsidy duration limit?

- Adults (21 and older): The CHCP subsidy is available as a one-time resource for a maximum of 3 years in a row. Adult members who have received the subsidy for more than 3 years will not be eligible to reapply for the subsidy. Adult members who do not reapply in consecutive years will lose future eligibility.
- Children (Under 21): Children can get the CHCP subsidy until they turn 21, no matter how long they've been in the program. All members, including children, must reapply every year.

5. I can't afford to pay for coverage through Covered California. Can I still qualify for CHCP?

Not being able to pay Covered California premiums does not qualify you for CHCP. You must meet the CHCP income and other rules to qualify.

6. Do I qualify for CHCP if I am offered health coverage through an employer?

To be eligible for CHCP, applicants must not have access to an employer plan that is considered affordable. CHCP follows federal guidelines for affordability. For 2026, the threshold that determines if an employer plan is affordable is if the premium is equal to less than 9.96% of one's annual household income. If you believe your job-based coverage is unaffordable (exceeds 9.96% of annual income), please submit proof of job-based coverage and include information on the cost of coverage and frequency of payment.

7. What other health coverage programs are available?

Find out if you qualify for Medi-Cal. This option may be available if you meet the following eligibility requirements:

- Children younger than 19 living in households with income up to 266% of the Federal Poverty Level (FPL) ($42,454 for an individual or $87,780 for a family of 4 in 2026), regardless of immigration status.
- Adults 19-64 with household income up to 138% of the FPL ($22,025 for an individual or $45,540

for a family of 4 in 2026). Beginning 1/1/2026, adults 19 and older must have an eligible citizenship or immigration status to qualify.

- Pregnant individuals with income up to 213% of the FPL ($33,995 for an individual or $70,290 for a family of 4 in 2026), regardless of immigration status.
- Seniors and people with disabilities with limited household income and assets may also qualify.

Kaiser Permanente is a Medi-Cal provider and may be available to you. For more information, please 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.

Find out if you qualify for 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.

8. What if the person listed as the primary member is not eligible for CHCP?

If the primary member is no longer eligible, then do not submit this Reapplication for subsidy form. Instead, eligible members who want to continue on CHCP next year must submit a new application during Open Enrollment, which begins November 1. Visit us at **kp.org/ca-chcp/howtoenroll** starting November 1 for information on how to apply during Open Enrollment.

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SECTION 1: Member information (Required)

Primary member

The primary member is the person who is covered by the health plan and reapplying for the Kaiser Permanente Community Health Coverage Program (CHCP) subsidy. If reapplying for a child under 18, complete section 1 with the child's information and also complete section 2 with the parent or legal guardian information.

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

Preferred language spoken (if not English)

Preferred language read (if not English)

Email

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

Is the primary member…

- Offered health coverage through a job?* ☐ Yes ☐ No
- Eligible for Medi-Cal?*† ☐ Yes ☐ No
- Eligible for Medicare?*† ☐ Yes ☐ No
- Eligible for other low-cost health insurance, such as through Covered California?*† ☐ Yes ☐ No

*Indicates a required field

†If the applicant is not eligible for other coverage, or has received a denial of coverage notification, select "No".

SECTION 2: Parent or legal guardian (if applicable)

Only complete this section if you are the parent or legal guardian of the minor (child under 18) listed in section 1. The parent or legal guardian listed here will not be considered for the CHCP subsidy or health plan coverage.

First name

MI

Last name

Date of birth (mm/dd/yyyy)

Medical Record Number (if available)

Gender
☐ Male ☐ Female ☐ Undeclared

Home phone

Mobile phone

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

City

State

ZIP code

Preferred language spoken (if not English)

Preferred language read (if not English)

Email

SECTION 3: Family information (if applicable)

Spouse/ domestic partner (if applicable)

Please complete this section for the spouse/domestic partner who is covered by the health plan and reapplying for the Kaiser Permanente Community Health Coverage Program (CHCP) subsidy. Only complete this section if the primary member listed in section 1 is an adult and is seeking coverage for their spouse or domestic partner.

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 CHCP or other programs that provide health coverage.

Is the spouse/domestic partner…

- Offered health coverage through a job?* ☐ Yes ☐ No
- Eligible for Medi-Cal?*† ☐ Yes ☐ No
- Eligible for Medicare?*† ☐ Yes ☐ No
- Eligible for other low-cost health insurance, such as through Covered California?*† ☐ Yes ☐ No

*Indicates a required field

†If the applicant is not eligible for other coverage, or has received a denial of coverage notification, select "No".

(continues)

SECTION 3: Family information *(continued)*

Dependent 1

Please complete this section for each additional dependent who is covered by the health plan and reapplying for the Kaiser Permanente Community Health Coverage Program (CHCP) subsidy. Only complete this section if the primary member listed in section 1 is an adult and is seeking coverage for additional dependents, OR if member in section 1 is a minor and the parent/legal guardian (listed in section 2) has additional minors seeking coverage.

If you have more than 3 dependents reapplying, 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 member

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

Is the dependent …

- Offered health coverage through a job?* ☐ Yes ☐ No
- Eligible for Medi-Cal?*† ☐ Yes ☐ No
- Eligible for Medicare?*† ☐ Yes ☐ No
- Eligible for other low-cost health insurance, such as through Covered California?*† ☐ Yes ☐ No

*Indicates a required field

†If the applicant is not eligible for other coverage, or has received a denial of coverage notification, select "No".

(continues)

SECTION 3: Family information *(continued)*

Dependent 2

Please complete this section for each additional dependent who is covered by the health plan and reapplying for the Kaiser Permanente Community Health Coverage Program (CHCP) subsidy. Only complete this section if the primary member listed in section 1 is an adult and is seeking coverage for additional dependents, OR if member in section 1 is a minor and the parent/legal guardian (listed in section 2) has additional minors seeking coverage.

First name

MI

Last name

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

Medical record number (if available)

Gender
☐ Male ☐ Female
☐ Undeclared

Relationship to primary member

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

Is the dependent …

- Offered health coverage through a job?* ☐ Yes ☐ No
- Eligible for Medi-Cal?*† ☐ Yes ☐ No
- Eligible for Medicare?*† ☐ Yes ☐ No
- Eligible for other low-cost health insurance, such as through Covered California?*† ☐ Yes ☐ No

Dependent 3

Please complete this section for each additional dependent who is covered by the health plan and reapplying for the CHCP subsidy. Only complete this section if the primary member listed in section 1 is an adult and is seeking coverage for additional dependents, OR if member/in section 1 is a minor and the parent/legal guardian (listed in section 2) has additional minors seeking coverage.

First name

MI

Last name

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

Medical record number (if available)

Gender
☐ Male ☐ Female
☐ Undeclared

Relationship to primary member

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

Is the dependent …

- Offered health coverage through a job?* ☐ Yes ☐ No
- Eligible for Medi-Cal?*† ☐ Yes ☐ No
- Eligible for Medicare?*† ☐ Yes ☐ No
- Eligible for other low-cost health insurance, such as through Covered California?*† ☐ Yes ☐ No

*Indicates a required field

†If the applicant is not eligible for other coverage, or has received a denial of coverage notification, select "No".

SECTION 4: Household income **(Required)**

Your family size, household income, and proof of income documents help us determine if you qualify for CHCP.

(A) How many family members† live 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.) This usually includes you and the immediate family members who live with you. Like your spouse and your children 18 and younger (up to 23 if a student).*

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

Do not include working child dependents (18 and younger, or up to 23 if a student) whose income is below the tax-filing threshold ($15,750 in 2025 Do not submit proof of income documents for them either.

☐ I do not work / No one in my household works.
(If this is selected, skip sections C & D and **do not submit income documentation.**)

(C) Tell us about your household income. Select ALL options that apply.

You may check more than one box if different income situations apply to different members of your household. When multiple options are selected, any amounts provided and submitted as proof will be added together.

Option 1: No proof of income **If one or more household members do not have proof of income** (for example, no paystub or W-2), check the box below and provide the monthly household income amount for those members.

☐ **I attest that one or more members of my household have no proof of income.**
The combined **MONTHLY** gross income for these household members is $_____ per month.
(If this option is selected, **do not submit income documentation for these household members.**)

Option 2: Income varies **If one or more household members have income that varies** (for example, tips, overtime, or commissions), check the box below and provide an estimate of their income.

☐ **I attest that one or more members of my household have income that varies.** The combined expected gross **ANNUAL** income for these household members in **2026** is $_____.
(If this option is selected, **do not submit income documentation for these household members.**) Please include the amount received so far this year and an estimate of the expected amount for the remainder of the year.

Option 3: Proof of income provided **If one or more household members have proof of income,** check the box below.

☐ **I attest that one or more members of my household have proof of income,** and I will include that documentation with my application.

If your household has proof of income, please submit documentation for the income you received. Attach copies of the most current proof of income for EVERY family member that contributes to household income.
Qualifying income and relevant examples are listed below:

Wages and/or tips:	Your last 2 paycheck stubs, W-2 from employer, or last year's 1040 tax form. Note: if tax form is submitted, no other proof of income is required.
Self-employment:	A profit and loss form, or schedule C and page 1 of last year's federal income tax return (the adjusted gross income page)
Social security payments:	Award letters for social security and Social Security Disability Insurance (SSDI) payments
Unemployment benefits	Award letters for unemployment benefits
Alimony received	Submit court documents or a letter from your former spouse detailing payment information.(only if your divorce or separation was finalized before January 1, 2019)
Student financial aid used for living expenses (Student loans and financial aid for tuition/education expenses are not counted as income.)	
Pension/retirement income	
Rental income from property you own and lease	
Interest or investment income and annuities	
Other income like capital gains, clergy earnings, or gambling income	

Please explain any special situation that we should consider when we are reviewing your income documents.
(if applicable) _____

(continues)

SECTION 4: Household income (Required)

(D) Attach copies of the most current proof of tax deductions for EVERY family member that contributes to household income. (if applicable)

Qualifying Deductions:

- **Self-employed expenses:** Only if submitting a profit and loss form. If submitting a schedule C of last year's federal income tax return, we will review the adjusted gross income on page 1.
- **Alimony you pay:** Submit court documents or a letter from your former spouse detailing payment information. (only if your divorce or separation was finalized before January 1, 2019)
- **Interest you pay on a student loan:** Submit your 1098-E Student Loan Interest form from the most recent tax year.
- **IRA contributions:** Submit your Form 5498 from the most recent tax year. (if you do not have a retirement account through a job)
- **Teacher expenses** (if you're a teacher and pay for supplies out-of-pocket)
- **Health Savings Account (HSA) deposits:** Submit your completed Form 8889. (in limited situations)

SECTION 5: Options if you're not eligible

If you no longer qualify, you will no longer receive our CHCP subsidy for premiums and out-of-pocket costs but you'll remain enrolled in the 2027 Kaiser Permanente - Platinum 90 HMO plan. **You'll have to pay your full monthly premiums and out-of-pocket costs,** unless you ask us to disenroll you from the Kaiser Permanente - Platinum 90 HMO plan by checking the box below, or until you fail to pay the full premium.

Want us to disenroll you if you no longer qualify?

If you'd like us to cancel your Kaiser Permanente 2027 Kaiser Permanente - Platinum 90 HMO plan coverage, check the box below.

☐ Disenroll all individuals on my plan **who no longer qualify** from the Kaiser Permanente Kaiser Permanente - Platinum 90 HMO plan effective December 31, 2026.

If you do not check the box and if your reapplication for the CHCP subsidy is not approved, you'll remain enrolled in Kaiser Permanente's 2027 Kaiser Permanente - Platinum 90 HMO plan, but you'll be responsible for the full monthly premium and out-of-pocket costs for services you receive. Your first bill will arrive in early December 2026. If you have questions, call us at **1-800-464-4000 (TTY 711).**

You may also submit a request in writing or call us at **1-800-464-4000 (TTY 711)** to cancel your Kaiser Permanente 2027 Kaiser Permanente - Platinum 90 HMO plan coverage. Contact us by November 30, 2026 to avoid receiving your first bill.

SECTION 6: Community Partner Verification

Note for Community Partners: This section should only be completed by Community Partners who have entered into a Business Associate Agreement (BAA) with Kaiser Permanente for HIPAA compliance. If your organization does not have a BAA in place, please skip this section and assist the applicant with completing section 7 for the Authorized Representative and HIPAA authorization.

Organization name

Organization phone

– –

Phone extension (if applicable)

Organization email address

Community partner representative

I attest that I assisted the applicant(s) with this application for the Kaiser Permanente Community Health Coverage Program (CHCP). I understand and agree that I will commit to serving as a point of contact for Kaiser Permanente Membership Administration regarding follow up or questions related to this application.

X

Signature of community partner representative

Date (mm/dd/yyyy)

/ /

(continues)

SECTION 7: 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)

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.

X

Date (mm/dd/yyyy)

/ /

Primary applicant (parent or legal guardian for children under 18)

This authorization lasts until December 31, 2027 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 939095, San Diego, CA 92193-9095 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 do not sign this authorization, we will still process your application for the Kaiser Permanente Community Health Coverage Program (CHCP) 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)

/ /

Primary applicant (parent or legal guardian for children under 18)

SECTION 8: Sign the reapplication 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. Kaiser Permanente reserves the right to request additional documentation at any time to verify our member's eligibility. Membership approval for Kaiser Permanente's Community Health Coverage Program (CHCP) is not guaranteed as it is based on eligibility and availability.

X

Date (mm/dd/yyyy)

/ /

Primary applicant (parent or legal guardian for children under 18)

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

Notice of Language Assistance

English: ATTENTION. Timely language assistance is available at no cost to you. You can ask for interpreter services, including sign language interpreters. You can ask for materials translated into your language or alternative formats, such as braille, audio, or large print. You can also request auxiliary aids and devices at our facilities. Call our Member Services department for help. Member Services is closed on major holidays.

- Medicare, including D-SNP: **1-800-443-0815** (TTY **711**), 8 a.m. to 8 p.m., 7 days a week
- Medi-Cal: **1-855-839-7613** (TTY **711**), 24 hours a day, 7 days a week
- All others: **1-800-464-4000** (TTY **711**), 24 hours a day, 7 days a week

Arabic: تنبيه. المساعدة اللغوية الفورية متوفرة بدون تكلفة عليك. يمكنك طلب خدمات الترجمة، بما في ذلك مترجمي لغة الإشارة. يمكنك طلب وثائق مترجمة بلغتك أو بصيغ بديلة مثل طريقة برايل للمكفوفين أو ملف صوتي أو الطباعة بأحرف كبيرة. يمكنك أيضًا طلب وسائل مساعدة وأجهزة مساعدة في مرافقنا. اتصل بقسم خدمات الأعضاء (Member Services) لدينا للحصول على المساعدة. لا تعمل خدمات الأعضاء في العطلات الرئيسية.

- Medicare، بما في ذلك D-SNP على : **1-800-443-0815** (TTY **711**)، 8 صباحاً إلى 8 مساءً، 7 أيام في الأسبوع
- Medi-Cal: على **1-855-839-7613** (TTY **711**)، 24 ساعة في اليوم، 7 أيام في الأسبوع
- الآخرين جميعاً: **1-800-464-4000** (TTY **711**)، 24 ساعة في اليوم، 7 أيام في الأسبوع

Armenian: ՈՒՇԱԴՐՈՒԹՅՈՒՆ: Ժամանակին տրամադրվող լեզվական աջակցությունը հասանելի է ձեզ անվճար: Դուք կարող եք խնդրել բանավոր թարգմանության ծառայություններ, այդ թվում՝ ժեստերի լեզվի թարգմանիչներ: Դուք կարող եք խնդրել ձեր լեզվով թարգմանված նյութեր կամ այլընտրանքային ձևաչափեր, ինչպիսիք են՝ բրայլը, ձայնագրությունը կամ խոշոր տառատեսակը: Դուք կարող եք նաև դիմել օժանդակ աջակցության և սարքերի համար, որոնք առկա են մեր հաստատություններում: Օգնության համար զանգահարեք մեր Անդամների

սպասարկման բաժին (Member Services): Անդամների սպասարկման բաժինը փակ է հիմնական տոն օրերին:

- Medicare, ներառյալ D-SNP՝ **1-800-443-0815** (TTY **711**), 8 a.m.-ից 8 p.m.-ը, շաբաթը 7 օր
- Medi-Cal՝ **1-855-839-7613** (TTY **711**), օրը 24 ժամ, շաբաթը 7 օր
- Մյուս բոլորը՝ **1-800-464-4000** (TTY **711**), օրը 24 ժամ, շաբաթը 7 օր

Chinese：请注意。我们可及时提供免费语言协助。您可以要求获取口译服务，包括手语翻译员。您可以要求将资料翻译成您所使用的语言或其他格式的版本，如盲文、音频或大字版。您还可以要求使用我们设施中的语言辅助工具和设备。请联系会员服务部 (Member Services) 以获取帮助。重要节假日期间会员服务不开放。

- 联邦医疗保险计划 (Medicare)，包括 D-SNP：**1-800-443-0815** (TTY **711**)，每周 7 天，上午 8 点至晚上 8 点
- 加州医疗保健辅助计划：**1-855-839-7613** (TTY **711**)，每周 7 天，每天 24 小时
- 所有其他保险计划：**1-800-757-7585** (TTY **711**)，每周 7 天，每天 24 小时

Farsi: توجه. امکان بهره‌مندی از مساعدت زبانی بموقع به طور رایگان برای شما وجود دارد. می‌توانید خدمات ترجمه شفاهی را درخواست کنید، از جمله مترجمان زبان اشاره. همچنین می‌توانید مطالب ترجمه‌شده به زبان خودتان یا در قالب‌های جایگزین را درخواست کنید، از جمله خط بریل، فایل صوتی، یا چاپ با حروف درشت. همچنین می توانید امکانات و دستگاه‌های کمکی را از مراکز ما درخواست کنید. برای دریافت کمک، با خدمات اعضای (Member Services) ما تماس بگیرید. خدمات اعضاء، در تعطیلات رسمی بسته است.

- Medicare، شامل D-SNP: با شماره **1-800-443-0815** (TTY **711**)، از 8 صبح تا 8 عصر، در 7 روز هفته تماس بگیرید
- Medi-Cal: با شماره **1-855-839-7613** (TTY **711**)، در 24 ساعت شبانه‌روز، 7 روز هفته تماس بگیرید
- همه موارد دیگر: با شماره **1-800-464-4000** (TTY **711**)، در 24 ساعت شبانه‌روز، 7 روز هفته تماس بگیرید

Hindi: ध्यान दें। समय पर दी जाने वाली भाषा सहायता आपके लिए बिना किसी शुल्क के उपलब्ध है। आप दुभाषिया सेवाओं के लिए अनुरोध कर सकते हैं, जिसमें साइन लैंगुवेज के दुभाषिये भी शामिल हैं। आप सामग्रियों को अपनी भाषा या वैकल्पिक प्रारूप, जैसे कि ब्रेल, ऑडियो, या बड़े प्रिंट में अनुवाद करवाने के लिए भी कह सकते हैं। आप हमारे सुविधा-केंद्रों पर सहायक साधनों और उपकरणों का भी अनुरोध कर सकते हैं। सहायता के लिए हमारे सदस्य सेवा विभाग (Member Services) को कॉल करें। सदस्य सेवा विभाग मुख्य छुट्टियों वाले दिन बंद रहता है।

- Medicare, जिसमें D-SNP शामिल है: **1-800-443-0815** (TTY **711**), सुबह 8 बजे से रात 8 बजे तक, सप्ताह के 7 दिन
- Medi-Cal: **1-855-839-7613** (TTY **711**), दिन के चौबीस घंटे, सप्ताह के 7 दिन
- बाकी सभी: **1-800-464-4000** (TTY **711**), दिन के चौबीस घंटे, सप्ताह के 7 दिन

Hmong: FAJ SEEB. Muaj kev pab txhais lus pub dawb ncav sij hawm rau koj. Koj muaj peev xwm thov kom pab txhais lus, suav nrog kws txhais lus piav tes. Koj muaj peev xwm thov kom muab cov ntaub ntawv no txhais ua koj yam lus los sis ua lwm hom, xws li hom ntawv rau neeg dig muag xuas, tso ua suab lus, los sis luam tawm kom koj. Koj kuj tuaj yeem thov kom muab tej khoom pab dawb thiab tej khoom siv txhawb tau rau ntawm peb cov chaw kuaj mob. Hu mus thov kev pab rau ntawm peb Lub Chaw Pab Tswv Cuab (Member Services). Lub chaw pab tswv cuab kaw rau cov hnub so uas tseem ceeb.

- Medicare, suav nrog D-SNP: **1-800-443-0815** (TTY **711**), 8 teev sawv ntxov txog 8 teev tsaus ntuj, 7 hnub hauv ib lub vij
- Medi-Cal: **1-855-839-7613** (TTY **711**), 24 teev hauv ib hnub, 7 hnub hauv ib lub vij
- Tag nrho lwm yam: **1-800-464-4000** (TTY **711**), 24 teev hauv ib hnub, 7 hnub hauv ib lub vij

Japanese: ご注意。必要に応じた言語サポートを、無料でご利用いただけます。あなたは手話通訳を含む通訳サービスを依頼できます。点字、大型活字、または録音音声など、あなたの言語に翻訳された資料や別のフォーマットの資料を求めることができます。当社の施設では補助器具や機器の要請も承っております。支援が必要な方は、加入者サービス部門にお電話ください。加入者向けサービス (Member Services) は主要な休日では営業しておりません。

- D-SNP を含む Medicare: **1-800-443-0815** (TTY **711**)、午前 8 時から午後 8 時まで、年中無休
- Medi-Cal: **1-855-839-7613** (TTY **711**)、24 時間、年中無休
- その他全て: **1-800-464-4000** (TTY **711**)、24 時間、年中無休

Khmer (Cambodian): យកចិត្តទុកដាក់។
ជំនួយភាសាទាន់ពេលវេលាគឺមានដោយមិនគិតថ្លៃសម្រាប់អ្នក។ អ្នកអាចស្នើសុំសេវាអ្នកបកប្រែ រួមទាំងអ្នកបកប្រែភាសាសញ្ញាផងដែរ។ អ្នកអាចស្នើសុំឯកសារដែលត្រូវបានបកប្រែជាភាសារបស់អ្នក ឬទម្រង់ផ្សេងទៀតដូចជាអក្សរស្ទាប សំឡេង ឬអក្សរធំៗ។ អ្នកក៏អាចស្នើសុំជំនួយបន្ថែម និងឧបករណ៍ជំនួយនៅតាមកន្លែងរបស់យើងផងដែរ។ សូមទូរសព្ទទៅផ្នែកសេវាសមាជិក (Member Services) របស់យើងសម្រាប់ជំនួយ។ សេវាសមាជិកត្រូវបានបិទនៅថ្ងៃឈប់សម្រាកសំខាន់ៗ។

- Medicare រួមទាំង D-SNP: **1-800-443-0815** (TTY **711**) ពីម៉ោង 8 ព្រឹក ដល់ 8 យប់ 7 ថ្ងៃក្នុងមួយសប្តាហ៍
- Medi-Cal: **1-855-839-7613** (TTY **711**) 24 ម៉ោងក្នុងមួយថ្ងៃ 7 ថ្ងៃក្នុងមួយសប្តាហ៍
- ផ្សេងៗទៀត៖ **1-800-464-4000** (TTY **711**) 24 ម៉ោងក្នុងមួយថ្ងៃ 7 ថ្ងៃក្នុងមួយសប្តាហ៍

Korean: 안내 사항. 시기적절한 무료 언어 지원 제공. 수화 통역사를 포함한 통역 서비스를 요청할 수 있습니다. 한국어로 번역된 자료 또는 점자, 오디오 또는 큰 글씨와 같은 대체 형식의 자료를 요청할 수 있습니다. 저희 시설에서 보조 기구와 장치를 요청할 수도 있습니다. 가입자 서비스 (Member Services) 부서에 전화하여 도움을 요청하십시오. 주요 공휴일에는 가입자 서비스를 운영하지 않습니다.

- Medicare(D-SNP 포함), 주 7 일 오전 8 시~오후 8 시에 **1-800-443-0815** (TTY **711**) 번으로 문의
- Medi-Cal: **1-855-839-7613** (TTY **711**), 주 7 일, 하루 24 시간
- 기타: **1-800-464-4000** (TTY **711**), 주 7 일, 하루 24 시간

Laotian: ໂປດຊາບ. ມີການຊ່ວຍເຫຼືອດ້ານພາສາຢ່າງທັນເວລາໃຫ້ທ່ານໂດຍບໍ່ເສຍຄ່າ. ທ່ານສາມາດຂໍບໍລິການນາຍພາສາ, ລວມທັງນາຍພາສາມື. ທ່ານສາມາດຂໍໃຫ້ແປເອກະສານນີ້ເປັນພາສາຂອງທ່ານ ຫຼື ຮູບແບບອື່ນ, ເຊັ່ນ: ອັກສອນນູນ, ສຽງ, ຫຼື ການພິມຂະໜາດໃຫຍ່. ນອກຈາກນັ້ນ ທ່ານຍັງສາມາດຮ້ອງຂໍເຄື່ອງຊ່ວຍຟັງ ແລະ ອຸປະກອນການຊ່ວຍເຫຼືອໃນສະຖານທີ່ຂອງພວກເຮົາ. ໂທຫາພະແນກບໍລິການສະມາຊິກ (Member Services) ຂອງພວກເຮົາເພື່ອຂໍຄວາມຊ່ວຍເຫຼືອ. ພະແນກບໍລິການສະມາຊິກແມ່ນປິດໃນວັນພັກທີ່ສຳຄັນຕ່າງໆ.

- Medicare, ລວມທັງ D-SNP: **1-800-443-0815** (TTY **711**), 8 ໂມງເຊົ້າ ຫາ 8 ໂມງແລງ, 7 ມື້ຕໍ່ອາທິດ
- Medi-Cal: **1-855-839-7613** (TTY **711**), 24 ຊົ່ວໂມງຕໍ່ມື້, 7 ມື້ຕໍ່ອາທິດ
- ອື່ນໆ: **1-800-464-4000** (TTY **711**), 24 ຊົ່ວໂມງຕໍ່ມື້, 7 ມື້ຕໍ່ອາທິດ

Mien: CAU FIM JANGX LONGX OC. Ninh mbuo duqv jiepv sih liepc ziangx tengx faan waac bun meih muangx hingh mv zuqc heuc meih ndorqv nyaanh cingv oc. Meih corc haiv tov taux ninh mbuo tengx lorz faan waac bun meih, caux longc buoz wuv faan waac bun muangx. Meih aengx haih tov taux ninh mbuo dorh nyungc horngh jaa dorngx faan benx meih nyei waac a'fai fiev bieqc da'nyeic diuc daan, fiev benx domh nzangc-pokc bun hluo, bungx waac-qiez bun uangx, a'fai aamx bieqc domh zeiv-linh. Meih corc haih tov longc benx wuotc ginc jaa-dorngx tengx aengx caux jaa-sic nzie bun yiem njiec zorc goux baengc zingh gorn zangc. Mborqv finx lorz taux yie mbuo dinc zangc domh gorn Ziux Goux Baengc Mienh Nyei Dorngx (Member Services) liouh tov heuc ninh mbuo tengx nzie weih. Ziux goux baengc mienh nyei gorn zangc se gec mv zoux gong yiem gingc nyei hnoi-nyieqc oc.

- Medicare, caux D-SNP: **1-800-443-0815** (TTY **711**), yiem 8 dimv lungh ndorm taux 8 dimv lungh muonx, yietc norm leiz baaix zoux gong 7 hnoi
- Medi-Cal: **1-855-839-7613** (TTY **711**), yietc hnoi goux junh 24 norm ziangh hoc, yietc norm leiz baaix zoux gong 7 hnoi
- Yietc zungv da'nyeic diuc jauv-louc: **1-800-464-4000** (TTY **711**), yietc hnoi goux junh 24 norm ziangh hoc, yietc norm leiz baaix zoux gong 7 hnoi

Navajo: YÁ'ÁDÍÍŁTĮĮH. T'áá Áko T'áá Ałtso K'ad Díí T'áá Bíní'dée'go Bizaad Bee Na'anish Bééhózin, Doo Béeso Bee Na'al'a' Da. Tł'éé'góó tł'ízí'ígíí éí tséé' naalkáah sidá'ígíí bikáa' dah sidaaígíí, t'á'ii bik'eh dah na'ałkaígíí. T'á'ii éí tł'éé'góó tł'ízí'ígíí bik'eh dah deidiyós, t'á'ii éí bi'éé' bik'eh dah na'ałkaígíí bik'eh dah deidiyós. T'á'ii bik'eh dah na'ałkaígíí bikáa' dah na'ałkaígíí t'áá ałtso bik'eh dah deidiyós. Nihí Diné Bináhásdzą́ Baa Anáál'įį'ígíí Na'anish (Member Services) Bá Haz'ą́ Bii' Bee Áká Shich'į' Hodiilnih. Dinéełchí Na'anish Bá Haz'ą́ Éí 'Ayóó'át'éego Niheezhch'įįhgo Yáá'ah Nits'ááh Daaztsáál.

- Medicare, bikáa’ dah deidiyós D-SNP: **1-800-443-0815** (TTY **711**), 8 a.m. góó 8 p.m., 7 jį t’ááłá’í damóo
- Medi-Cal: **1-855-839-7613** (TTY **711**), 24 tł’ohch’oolí t’ááłá’í jį, 7 jį t’ááłá’í damóo
- T’áá ał’ąą: **1-800-464-4000** (TTY **711**), 24 tł’ohch’oolí t’ááłá’í jį, 7 jį t’ááłá’í damóo

Punjabi: ਧਿਆਨ ਦਿਓ। ਸਮੇਂ ਸਿਰ ਦਿੱਤੀ ਜਾਣ ਵਾਲੀ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਤੁਹਾਡੇ ਲਈ ਬਿਨਾਂ ਕਿਸੇ ਲਾਗਤ ਦੇ ਉਪਲਬਧ ਹੈ। ਤੁਸੀਂ ਦੁਭਾਸ਼ਿਏ ਦੀਆਂ ਸੇਵਾਵਾਂ ਦਿੱਤੇ ਜਾਣ ਲਈ ਕਹਿ ਸਕਦੇ ਹੋ, ਜਿਸ ਵਿੱਚ ਸਾਈਨ ਲੈਂਗੁਵੇਜ਼ ਦੇ ਦੁਭਾਸ਼ਿਏ ਵੀ ਸ਼ਾਮਲ ਹਨ। ਤੁਸੀਂ ਸਮੱਗਰੀਆਂ ਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ, ਜਾਂ ਕਿਸੇ ਵੈਕਲਪਿਕ ਫਾਰਮੈਟ, ਜਿਵੇਂ ਕਿ ਬ੍ਰੇਲ, ਆਡੀਓ, ਜਾਂ ਵੱਡੇ ਪ੍ਰਿੰਟ ਵਿੱਚ ਅਨੁਵਾਦਿਤ ਕਰਨ ਲਈ ਵੀ ਕਹਿ ਸਕਦੇ ਹੋ। ਤੁਸੀਂ ਸਾਡੀਆਂ ਸਹੂਲਤਾਂ 'ਤੇ ਸਹਾਇਕ ਏਡਜ਼ ਅਤੇ ਉਪਕਰਨਾਂ ਲਈ ਵੀ ਬੇਨਤੀ ਕਰ ਸਕਦੇ ਹੋ। ਮਦਦ ਲਈ ਸਾਡੇ ਮੈਂਬਰਾਂ ਸੇਵਾਵਾਂ (Member Services) ਦੇ ਵਿਭਾਗ ਨੂੰ ਕਾੱਲ ਕਰੋ। ਮੈਂਬਰਾਂ ਸੇਵਾਵਾਂ ਦਾ ਵਿਭਾਗ ਮੁੱਖ ਛੁਟੀਆਂ ਵਾਲੇ ਦਿਨ ਬੰਦ ਰਹਿੰਦਾ ਹੈ।

- Medicare, ਜਿਸ ਵਿੱਚ D-SNP ਵੀ ਸ਼ਾਮਲ ਹੈ: **1-800-443-0815** (TTY **711**), ਸਵੇਰੇ 8 ਵਜੇ ਤੋਂ ਸ਼ਾਮ 8 ਵਜੇ ਤੱਕ, ਹਫ਼ਤੇ ਦੇ 7 ਦਿਨ
- Medi-Cal: **1-855-839-7613** (TTY **711**), ਦਿਨ ਦੇ 24 ਘੰਟੇ, ਹਫ਼ਤੇ ਦੇ 7 ਦਿਨ
- ਬਾਕੀ ਸਾਰੇ: **1-800-464-4000** (TTY **711**), ਦਿਨ ਦੇ 24 ਘੰਟੇ, ਹਫ਼ਤੇ ਦੇ 7 ਦਿਨ

Russian: ВНИМАНИЕ! Для Вас доступны бесплатные и своевременные услуги перевода. Вы можете запросить услуги устного перевода, в том числе услуги переводчика языка жестов. Вы также можете запросить материалы, переведенные на ваш язык или в альтернативных форматах, например шрифтом Брайля, крупным шрифтом или в аудиоформате. Вы также можете запросить дополнительные приспособления и вспомогательные устройства в наших учреждениях. Если Вам нужна помощь, позвоните в отдел обслуживания участников. Отдел обслуживания участников (Member Services) не работает в дни государственных праздников.

- Medicare, включая D-SNP: **1-800-443-0815** (TTY **711**), без выходных с 8:00 до 20:00.
- Medi-Cal: **1-855-839-7613** (TTY **711**), круглосуточно без выходных.
- Любые другие поставщики услуг: **1-800-464-4000** (TTY **711**), круглосуточно без выходных.

Spanish: ATENCIÓN. Se ofrece ayuda oportuna en otros idiomas sin ningún costo para usted. Puede solicitar servicios de interpretación, incluyendo intérpretes de lengua de señas. Puede solicitar materiales traducidos a su idioma o en formatos alternativos, como braille, audio o letra grande. También puede solicitar ayuda adicional y dispositivos auxiliares en nuestros centros de atención. Llame al Departamento de Servicio a los Miembros (Member Services) para pedir ayuda. Servicio a los Miembros está cerrado los días festivos principales.

- Medicare, incluyendo D-SNP: **1-800-443-0815** (TTY **711**), de 8 a. m. a 8 p. m., los 7 días de la semana.
- Medi-Cal: **1-855-839-7613** (TTY **711**), las 24 horas del día, los 7 días de la semana.
- Todos los otros: **1-800-788-0616** (TTY **711**) las 24 horas del día, los 7 días de la semana.

Tagalog: PAUNAWA. May magagamit na mabilis na tulong sa wika nang wala kang babayaran. Maaari kang humiling ng mga serbisyo ng interpreter, kasama ang mga interpreter sa sign language. Maaari kang humiling ng mga babasahin na nakasalin-wika sa iyong wika o sa mga alternatibong format, na tulad ng braille, audio, o malalaking titik. Puwede ka ring humiling ng mga karagdagang tulong at device sa aming mga pasilidad. Tawagan ang aming departamento ng Mga Serbisyo sa Miyembro (Member Services) para sa tulong. Ang mga serbisyo sa miyembro ay sarado sa mga pangunahing holiday.

- Medicare, kasama ang D-SNP: **1-800-443-0815** (TTY **711**), 8 a.m. hanggang 8 p.m., 7 araw sa isang linggo
- Medi-Cal: **1-855-839-7613** (TTY **711**), 24 oras sa isang araw, 7 araw sa isang linggo
- Ang lahat ng iba: **1-800-464-4000** (TTY **711**), 24 oras sa isang araw, 7 araw sa isang lingo

Thai: ส่งถึง มีบริการให้ความช่วยเหลือด้านภาษาแก่ท่านแบบทันทีโดยไม่มีค่าใช้จ่าย ท่านสามารถขอรับบริการล่าม รวมถึงล่ามภาษามือได้ ท่านสามารถขอให้แปลเอกสารเป็นภาษาของท่าน หรือในรูปแบบอื่นๆ เช่นอักษรเบรลล์ ไฟล์เสียง หรือตัวอักษรขนาดใหญ่ ท่านสามารถขอรับอุปกรณ์ ช่วยเหลือและอุปกรณ์เสริมได้ ณ สถานที่ให้บริการของเรา โทรติดต่อฝ่ายบริการสมาชิก (Member Services) ของเราเพื่อขอความช่วยเหลือได้ ฝ่ายบริการสมาชิกจะปิดทำการในวันหยุดราชการต่างๆ

- Medicare รวมถึง D-SNP: **1-800-443-0815** (TTY **711**) 8.00 น. ถึง 20.00 น. หรือ 7 วันต่อสัปดาห์
- Medi-Cal: **1-855-839-7613** (TTY **711**) ตลอด 24 ชั่วโมง หรือ 7 วันต่อสัปดาห์
- อื่นๆ ทั้งหมด: **1-800-464-4000** (TTY **711**) ตลอด 24 ชั่วโมง หรือ 7 วันต่อสัปดาห์

Ukrainian: УВАГА! Своєчасні послуги перекладача надаються безкоштовно. Ви можете залишити запит на послуги усного перекладу, зокрема мовою жестів. Ви можете зробити запит на отримання матеріалів, перекладених вашою мовою, або в альтернативних форматах, як-от надрукованим шрифтом Брайля чи великим шрифтом, а також у звуковому форматі. Крім того, ви можете зробити запит на отримання допоміжних засобів і пристроїв у закладах нашої мережі компаній. Якщо вам потрібна допомога, зателефонуйте у відділ обслуговування клієнтів (Member Services). Відділ обслуговування клієнтів зачинений у державні свята.

- Medicare, зокрема D-SNP: **1-800-443-0815** (TTY **711**), з 8:00 до 20:00, без вихідних.
- Medi-Cal: **1-855-839-7613** (TTY **711**), цілодобово, без вихідних.
- Усі інші надавачі послуг: **1-800-464-4000** (TTY **711**), цілодобово, без вихідних.

Vietnamese: LƯU Ý. Chúng tôi cung cấp dịch vụ hỗ trợ ngôn ngữ kịp thời, miễn phí cho quý vị. Quý vị có thể yêu cầu dịch vụ thông dịch, bao gồm cả thông dịch viên ngôn ngữ ký hiệu. Quý vị có thể yêu cầu tài liệu được dịch sang ngôn ngữ của quý vị hay định dạng thay thế, chẳng hạn như chữ nổi braille, băng đĩa thu âm hay bản in khổ chữ lớn. Quý vị cũng có thể yêu cầu các phương tiện và thiết bị phụ trợ tại các cơ sở của

chúng tôi. Gọi cho ban Dịch Vụ Hội Viên (Member Services) của chúng tôi để được trợ giúp. Ban Dịch Vụ Hội Viên không làm việc vào những ngày lễ lớn.

- Medicare, bao gồm cả D-SNP: **1-800-443-0815** (TTY **711**), 8 giờ sáng đến 8 giờ tối, 7 ngày trong tuần
- Medi-Cal: **1-855-839-7613** (TTY **711**), 24 giờ trong ngày, 7 ngày trong tuần
- Mọi chương trình khác: **1-800-464-4000** (TTY **711**), 24 giờ trong ngày, 7 ngày trong tuần

Nondiscrimination Notice

In this document, "we", "us", or "our" means Kaiser Permanente (Kaiser Foundation Health Plan, Inc, Kaiser Foundation Hospitals, The Permanente Medical Group, Inc., and the Southern California Medical Group). This notice is available on our website at **kp.org**.

Discrimination is against the law. We follow state and federal civil rights laws.

We do not discriminate, exclude people, or treat them differently because of age, race, ethnic group identification, color, national origin, cultural background, ancestry, religion, sex, gender, gender identity, gender expression, sexual orientation, marital status, physical or mental disability, medical condition, source of payment, genetic information, citizenship, primary language, or immigration status.

Kaiser Permanente provides the following services in a timely manner:

- No-cost aids and services to people with disabilities to help them communicate better with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (braille, large print, audio, accessible electronic formats, and other formats)
- No-cost language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, call our Member Services department at the numbers below. The call is free. Member services is closed on major holidays.

- Medicare, including D-SNP: **1-800-443-0815** (TTY **711**), 8 a.m. to 8 p.m., 7 days a week.
- Medi-Cal: **1-855-839-7613** (TTY **711**), 24 hours a day, 7 days a week.
- All others: **1-800-464-4000** (TTY **711**), 24 hours a day, 7 days a week.

Upon request, this document can be made available to you in braille, large print, audio, or electronic formats. To obtain a copy in one of these alternative formats, or another format, call our Member Services department and ask for the format you need.

How to file a grievance with Kaiser Permanente

You can file a discrimination grievance with us if you believe we have failed to provide these services or unlawfully discriminated in another way. You can file a grievance by phone, by mail, in person, or online. Please refer to your *Evidence of Coverage or Certificate of Insurance* for details. You can call Member Services for more information on the options that apply to you, or for help filing a grievance. You may file a discrimination grievance in the following ways:

- **By phone:** Call our Member Services department. Phone numbers are listed above.
- **By mail:** Download a form at **kp.org** or call Member Services and ask them to send you a form that you can send back.
- **In person:** Fill out a Complaint or Benefit Claim/Request form at a member services office located at a Plan Facility (go to your provider directory at **kp.org/facilities** for addresses)

- **Online:** Use the online form on our website at **kp.org**

You may also contact the Kaiser Permanente Civil Rights Coordinator directly at the addresses below:

Attn: Kaiser Permanente Civil Rights Coordinator
Member Relations Grievance Operations
P.O. Box 939001
San Diego CA 92193

How to file a grievance with the California Department of Health Care Services Office for Civil Rights *(For Medi-Cal Beneficiaries Only)*

You can also file a civil rights complaint with the California Department of Health Care Services Office for Civil Rights in writing, by phone or by email:

- **By phone:** Call DHCS Office of Civil Rights at **916-440-7370** (TTY **711**)
- **By mail:** Fill out a complaint form or send a letter to:

  Office of Civil Rights
  Department of Health Care Services
  P.O. Box 997413, MS 0009
  Sacramento, CA 95899-7413

  California Department of Health Care Services Office for Civil Rights Complaint forms are available at: http://www.dhcs.ca.gov/Pages/Language_Access.aspx

- **Online:** Send an email to CivilRights@dhcs.ca.gov

How to file a grievance with the U.S. Department of Health and Human Services Office for Civil Rights

You can file a discrimination complaint with the U.S. Department of Health and Human Services Office for Civil Rights. You can file your complaint in writing, by phone, or online:

- **By phone:** Call **1-800-368-1019** (TTY **711** or **1-800-537-7697**)
- **By mail:** Fill out a complaint form or send a letter to:

  U.S. Department of Health and Human Services
  200 Independence Avenue, SW
  Room 509F, HHH Building
  Washington, D.C. 20201

  U.S. Department of Health and Human Services Office for Civil Rights Complaint forms are available at: https://www.hhs.gov/ocr/office/file/index.html

- **Online:** Visit the **Office for Civil Rights Complaint Portal at: https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf**

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