KAISER PERMANENTE®

Hawaii Health Access Program Application for subsidy – 2025

Use this form to apply for a subsidy to pay your monthly premiums and most out-of-pocket costs under the Kaiser Permanente KP HI Standard Platinum 0/10. There is no cost to apply.

Enrollment in Kaiser Permanente's Hawaii Health Access 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 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 the Kaiser Permanente Hawaii Health Access Program will be considered for individuals who are uninsured and:

- Live in the Kaiser Foundation Health Plan, Inc. service area on Oahu and Maui
- Live in a household with income up to 300% of the Federal Poverty Level
- Not eligible for other public or private health coverage such as, but not limited to, Medicaid, Medicare, a job-based health plan, or financial help through the health benefit exchange

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

Step 4: Include additional documents

- QUEST (Medicaid) and/or health benefit exchange 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 form<s>, 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 (preferred):
  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 Hawaii Health Access Program or about this form, please call us at:

1-800-966-5955 (TTY 711)

Monday through Friday,
8 a.m. to 5 p.m. and Saturday,
8 a.m. to 12 p.m. Hawaii time
(closed major holidays).

Please note: Continued eligibility for the Hawaii Health Access 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 Hawaii Health Access 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 Hawaii Health Access Program.

2. **How much will I pay each month for the Kaiser Permanente Hawaii Health Access 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 Hawaii Health Access Program. You will remain enrolled in the KP HI Standard Platinum 0/10, **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 health benefit exchange. Can I still qualify for the Hawaii Health Access Program?**
   Not being able to pay health benefit exchange premiums does not qualify you for the Hawaii Health Access Program. You must meet the Hawaii Health Access Program income and other criteria to qualify.

5. **What other health coverage programs are available?**
   Find out if you qualify for QUEST (Medicaid). This option may be available to applicants born in the United States or lawful permanent residents who meet the following eligibility requirements:
   - Children younger than 19 living with households with income up to 313% of the Federal Poverty Level ($54,180 for an individual or $112,304 for a family of 4 in 2024). Kaiser Permanente is a Medicaid provider and may be available to you.
   - Adults 19 or older with household income up to 138% of the FPL ($23,888 for an individual or $49,514 fora family of 4 in 2024) Kaiser Permanente is a QUEST (Medicaid) provider and may be available to you.
   - Seniors, people with disabilities, and pregnant women with limited household income may also qualify.
   - For more information please visit kp.org/Medicaid/HI.

6. **Is the Hawaii Health Access Program a public benefit that could impact my ability to become a lawful permanent resident or U.S. citizen in the future?**
   No, the Hawaii Health Access 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 Hawaii Health Access Program?**
   If you're not accepted, there may be other health coverage programs available to you. See question 5 for more information.

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SECTION 1: Applicant information (Required)

Primary applicant The person who will be covered by the health plan and applying for the Hawaii Health Access Program subsidy. If applying 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

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 Hawaii Health Access 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, Deferred Action for Childhood Arrivals (DACA) recipients, and Resident Alien Permit Holders.

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.

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 Hawaii Health Access Program subsidy. Only complete this section if the primary applicant 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 the Hawaii Health Access 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]? _____

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, Deferred Action for Childhood Arrivals (DACA) recipients, and Resident Alien Permit Holders.

(continues)

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 Hawaii Health Access Program subsidy. Only complete this section if the primary applicant listed in section 1 is an adult and is seeking coverage for additional dependents, OR if applicant 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 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 Hawaii Health Access 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, Deferred Action for Childhood Arrivals (DACA) recipients, 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 Hawaii Health Access Program subsidy. Only complete this section if the primary applicant listed in section 1 is an adult and is seeking coverage for additional dependents, OR if applicant 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 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 Hawaii Health Access 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]? _____

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 Hawaii Health Access Program subsidy. Only complete this section if the primary applicant listed in section 1 is an adult and is seeking coverage for additional dependents, OR if applicant 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 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 Hawaii Health Access 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]? _____

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, Deferred Action for Childhood Arrivals (DACA) recipients, and Resident Alien Permit Holders.

SECTION 4: Household income

Your family size and household income help determine if you are eligible for the Hawaii Health Access Program.

Please use the questions and table below to help you determine total household income. Eligibility is based on supporting proof of income documentation, not information written in the table below.

(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) You can use the table below to help calculate your total household income.

- 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 ($13,850 in 2024):
  - 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	$ *	$	$

REQUIRED: To determine eligibility, you must attach copies of the most current proof of income for the items you included in the table above. Examples include:

- Pay stubs
- Award letters for Social Security or unemployment benefits
- W-2 from current employer
- Letter from employer

If there is no proof of income, check this box and fill in the blank with monthly household income:

☐ I attest to no proof of income and a monthly household income of $_____.

We will calculate your total yearly household income by adding up the amounts shown in your submitted proof of income documents, and subtracting your deductions (if any). 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 ☐ I do not work ☐ Self employed

☐ Recent job change ☐ Seasonal (please explain) _____

☐ Other (please explain) _____

*Indicates a required field

(continues)

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: Community Partner Verification

Organization name

Organization phone

- -

Organization email address

Community partner representative

I attest that I assisted the applicant(s) with this application for the Hawaii Health Access Program. 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)

/ /

SECTION 6: 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 application.

X

Date (mm/dd/yyyy)

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

This authorization lasts two (2) years from your signature date 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 don't sign this authorization, we will still process your application for the Hawaii Health Access 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 7: 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 Hawaii Health Access 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)

In Hawaii, all plans are offered and underwritten by Kaiser Foundation Health Plan, Inc., 711 Kapiolani Blvd., Honolulu, HI 96813.

NONDISCRIMINATION NOTICE

Kaiser Foundation Health Plan, Inc. (Kaiser Health Plan) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Kaiser Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. We also:

- Provide free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats, such as large print, audio, and accessible electronic formats

- Provide free 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 **1-800-966-5955** (TTY: **711**)

If you believe that Kaiser Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by mail or phone at:

Membership Services
Attn: Kaiser Civil Rights Coordinator
711 Kapiolani Blvd
Honolulu, HI 96813
1-800-966-5955

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 1-800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

HELP IN YOUR LANGUAGE

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call **1-800-966-5955** (TTY: **711**).

Cebuano (Bisaya) ATENSYON: Kung nagsulti ka og Cebuano, aduna kay magamit nga mga serbisyo sa tabang sa lengguwahe, nga walay bayad.
Tawag sa **1-800-966-5955** (TTY: **711**).

中文 (Chinese) 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **1-800-966-5955**（TTY：**711**）。

Chuuk (Chukese) MEI AUCHEA: Ika iei foosun fonuomw: Foosun Chuuk, iwe en mei tongeni omw kopwe angei aninisin chiakku, ese kamo.
Kori **1-800-966-5955** (TTY: **711**).

ʻŌlelo Hawaiʻi (Hawaiian) E NĀNĀ MAI: Inā hoʻopuka ʻoe i ka ʻōlelo Hawaiʻi, hiki iā ʻoe ke loaʻa i ke kōkua manuahi. E kelepona i ka helu **1-800-966-5955** (TTY: **711**).

Iloko (Ilocano) PAKDAAR: No agsasaoka iti Ilokano, dagiti awan bayadna a serbisio a para iti beddeng ti lengguahe ket sidadaan para kenka.
Awagan ti **1-800-966-5955** (TTY: **711**)

日本語 (Japanese) 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。**1-800-966-5955**（TTY: **711**）まで、お電話にてご連絡ください。

한국어 (Korean) 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1-800-966-5955** (TTY: **711**) 번으로 전화해 주십시오.

ລາວ (Laotian) ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ **1-800-966-5955** (TTY: **711**).

Kajin Majōḷ (Marshallese) LALE: Ñe kwōj kōnono Kajin Ṃajōḷ, kwomaroñ bōk jerbal in jipañ ilo kajin ṇe aṃ ejjeḷọk wōṇāān. Kaaloḳ **1-800-966-5955** (TTY: **711**).

Naabeehó (Navajo) Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih **1-800-966-5955** (TTY: **711**).

Lokaiahn Pohnpei (Pohnpeian) MEHN KAIR: Ma komw kin lokiaiahn Pohnpei, wasahn sawas en palien lokaia kak sawas ni sohte isais.
Koahl nempe **1-800-966-5955** (TTY: **711**).

Faa-Samoa (Samoan) MO LOU SILAFIA: Afai e te tautala Gagana fa'a Sāmoa, o loo iai auaunaga fesoasoani, e fai fua e leai se totogi, mo oe, Telefoni mai: **1-800-966-5955** (TTY: **711**).

Español (Spanish) ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-800-966-5955** (TTY: **711**).

Tagalog (Tagalog) PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad.
Tumawag sa **1-800-966-5955** (TTY: **711**).

Lea Faka-Tonga (Tongan) FAKATOKANGA'I: Kapau ʻoku ke Lea Faka-Tonga, ko e kau tokoni fakatonu lea ʻoku nau fai atu ha tokoni ta'etotongi, pea teke lava ʻo ma'u ia. Telefoni mai **1-800-966-5955** (TTY: **711**).

Tiếng Việt (Vietnamese) CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-800-966-5955** (TTY: **711**).

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