KAISER PERMANENTE®

# Community Health Access Program Subsidy Eligibility Form – 2019

Use this form to apply for a subsidy to help pay your monthly premiums and most out-of-pocket medical costs under the Kaiser Permanente VA Gold 0/20 plan.

Enrollment in Kaiser Permanente's Community Health Access Program is available during the Individuals and Families annual open enrollment and special enrollment periods. In general, the special enrollment period is 60 days after a qualifying life event such as marriage, birth or adoption of a child, divorce, or loss of job and job-based health coverage. To apply, follow these steps:

**Step 1: Fill out the Subsidy Eligibility Form**

- Use only black or blue ink to complete the form.
- Answer all questions completely.
- Sign the form.
- Provide proof of guardianship if applicable.
- Make a copy of the completed form for your records.

**Step 2: Apply for Health Coverage**

Complete 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.
- See Section 4 of this form for more examples of proof of income. If you have received an affordability exemption from the federal government, please include a copy of the exemption letter.

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## We're here to help:

The Community Health Access Program provides a subsidy to help pay your monthly premiums and most out-of-pocket medical costs under the Kaiser Permanente VA Gold 0/20 plan.

The Kaiser Permanente subsidy is offered as part of Kaiser Permanente's Community Health Access Program. Eligibility for the Kaiser Permanente Community Health Access Program will be considered for individuals who are uninsured and:

- Live in the Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., service area, excluding the District of Columbia
- Live in a household with incomes up to 300% of the federal poverty level
- Do not have access to any other public or private health coverage including, but not limited to, Medicaid/FAMIS, Medicare, a job-based health plan, or coverage through the Virginia Health Insurance Marketplace

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

*(continued)*

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

- Student loan interest – include your last student loan statement
- Alimony paid – include a copy of your check
- Self-employed – include all receipts

**Step 4: Mail your forms and proof of income**

Mail your completed Subsidy Eligibility Form, Kaiser Permanente Application for Health Coverage, proof of current income, and any income deductions to:

- California Service Center
  Attn: CHC
  P.O. Box 939095
  San Diego, CA 92193-9095
  Fax: **858-614-3344**

## We're here to help:

If you have any questions about the Community Health Access Program or about this form, please call Member Services at:

**1-800-777-7902** (TTY **711**)

Monday through Friday,
7:30 a.m. to 5:30 p.m. Eastern time (ET).

Eligibility rules for Kaiser Permanente's Community Health Access Program may change at any time.
This Community Health Access Program subsidy is limited and subject to availability.

**Please note:** 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 any other purpose required by law.

# Frequently asked questions

1. **How long does it take to determine eligibility for Kaiser Permanente's Community Health Access Program?**
   Completed forms that include all required documentation can take up to 30 business days to process. If information is missing, it may take longer than 30 days and you may miss the deadline for applying. Completion of this form does not guarantee enrollment in Kaiser Permanente's Community Health Access Program.

2. **What if I'm not accepted into the Community Health Access Program?**
   If you are not accepted and still want to buy a Kaiser Permanente Individuals and Families plan on your own, please call the National Direct Sales Center at **1-800-494-5314** or visit **buykp.org**.

3. **How much will I pay each month for the Kaiser Permanente Community Health Access Program?**
   There is no monthly payment required. Kaiser Permanente will subsidize the full monthly premium.

4. **What happens when I no longer meet the eligibility requirements for the Community Health Access Program?**
   When you no longer meet our eligibility requirements, you will be disenrolled from Kaiser Permanente's Community Health Access Program, which includes the Kaiser Permanente subsidy and medical financial assistance. You will remain enrolled in the VA Gold 0/20 plan, but you will be responsible for paying the full monthly premium and any out-of-pocket costs unless you ask us to end your membership or until you fail to pay the full premium.

5. **What other health coverage programs are available?**
   - Consider Medicaid/FAMIS. This option may be available if you were born in the United States, you are a legal resident, and you meet certain eligibility requirements such as: children, seniors, and people with disabilities, or certain parents under the age of 65 with income at or below 133% of the federal poverty level (for example: $16,146 for an individual or $33,383 for a family of 4, per 2018 guidelines). Kaiser Permanente is a Medicaid provider and may be available to you. Please visit **kp.org/medicaid/va** for more information.
   - Buy health coverage through your state's Health Insurance Marketplace (also known as the Exchange). If you qualify, you may get help paying for your plan premiums or out-of-pocket costs. For more information, visit **HealthCare.gov**.

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## SECTION 1: Parent or legal guardian (if the primary applicant is a child under 18)

First name MI

Last name

Date of birth (mm/dd/yyyy) Gender ☐ Male ☐ Female

Mailing address (P. O. boxes acceptable)

City State ZIP code Phone

## SECTION 2: Applicant information

**Primary applicant** Is the person who will be covered by the health plan and requesting the Community Health Access Program subsidy. If applying for a child under 18, the parent or guardian should provide the child's information below.

First name MI

Last name

Date of birth (mm/dd/yyyy) Gender ☐ Male ☐ Female Medical record number (if any)

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

City State ZIP code Home phone

Email address (optional) Mobile phone

*(continues)*

## SECTION 2: Applicant information *(continued)*

Please answer the following questions about the primary applicant who will be covered by the health plan. This information is only used to find out if the primary applicant is eligible for the Community Health Access Program or other programs that provide health coverage. Is the primary applicant who will be covered by the health plan …

A U.S. citizen? ☐ Yes ☐ No

A legal permanent resident? ☐ Yes ☐ No

If Yes, how many years has the primary member been a legal permanent resident? _____

Currently receiving or have access to a job-based health plan or another health plan? ☐ Yes ☐ No

A current or former member of Community Health Access Program? ☐ Yes ☐ No

## SECTION 3: Family information

**Family member 1**

Please complete this section for each additional family member applying for the Community Health Access Program subsidy. If an applicant is under 18, the parent/guardian should complete this section for the applicant.

First name MI

Last name

Date of birth (mm/dd/yyyy) / / Gender ☐ Male ☐ Female Medical record number (if any)

Relationship to primary applicant

Please answer the following questions about the family member. This information is only used to find out if the family member is eligible for the Community Health Access Program or other programs that provide health coverage. Is the family member who will be covered by the health plan …

A U.S. citizen? ☐ Yes ☐ No

A legal permanent resident? ☐ Yes ☐ No

If Yes, how many years has the family member been a legal permanent resident? _____

Currently receiving or have access to a job-based health plan or another health plan? ☐ Yes ☐ No

A current or former member of Community Health Access Program? ☐ Yes ☐ No

*(continues)*

## SECTION 3: Family information *(continued)*

**Family member 2**

Please complete this section for each additional family member applying for the Community Health Access Program subsidy. If an applicant is under 18, the parent/guardian should complete this section for the applicant.

First name

MI

Last name

Date of birth (mm/dd/yyyy)

/ /

Gender

☐ Male ☐ Female

Medical record number (if any)

Relationship to primary applicant

**Please answer the following questions about the family member. This information is only used to find out if the family member is eligible for the Community Health Access Program or other programs that provide health coverage. Is the family member who will be covered by the health plan …**

A U.S. citizen? ☐ Yes ☐ No

A legal permanent resident? ☐ Yes ☐ No

If Yes, how many years has the family member been a legal permanent resident? _____

Currently receiving or have access to a job-based health plan or another health plan? ☐ Yes ☐ No

A current or former member of Community Health Access Program? ☐ Yes ☐ No

*(continues)*

## SECTION 3: Family information *(continued)*

**Family member 3**

Please complete this section for each additional family member applying for the Community Health Access Program subsidy. If an applicant is under 18, the parent/guardian should complete this section for the applicant.

First name

MI

Last name

Date of birth (mm/dd/yyyy)

Gender ☐ Male ☐ Female

Medical record number (if any)

Relationship to primary applicant

Please answer the following questions about the family member. This information is only used to find out if the family member is eligible for the Community Health Access Program or other programs that provide health coverage. Is the family member who will be covered by the health plan …

A U.S. citizen? ☐ Yes ☐ No

A legal permanent resident? ☐ Yes ☐ No

If Yes, how many years has the family member been a legal permanent resident? _____

Currently receiving or have access to a job-based health plan or another health plan? ☐ Yes ☐ No

A current or former member of Community Health Access Program? ☐ Yes ☐ No

*(continues)*

## SECTION 3: Family information *(continued)*

**Family member 4**

Please complete this section for each additional family member applying for the Community Health Access Program subsidy. If an applicant is under 18, the parent/guardian should complete this section for the applicant.

First name

MI

Last name

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

Gender ☐ Male ☐ Female

Medical record number (if any)

Relationship to primary applicant

Please answer the following questions about the family member. This information is only used to find out if the family member is eligible for the Community Health Access Program or other programs that provide health coverage. Is the family member who will be covered by the health plan …

A U.S. citizen? ☐ Yes ☐ No

A legal permanent resident? ☐ Yes ☐ No

If Yes, how many years has the family member been a legal permanent resident? _____

Currently receiving or have access to a job-based health plan or another health plan? ☐ Yes ☐ No

A current or former member of Community Health Access Program? ☐ Yes ☐ No

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

## SECTION 4: Household income

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

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

Include yourself, your spouse if you have one, and any dependents that you would include in your tax filing.
(You do not need to file taxes to apply for the Community Health Access Program.)

**How many people in the household help contribute to the household/family income?** _____

Please complete the table below.

- List the estimated yearly gross income (before taxes) for each person who contributes to your total household income.
- If an item doesn't apply, write "N/A" (not applicable).
- If more than 3 people contribute to your total household income, make a copy of this page, provide the same information for each additional person, and send it with your application.

| Estimated yearly gross income (before taxes) | Person 1 | Person 2 | Person 3 |
|---|---|---|---|
| Gross income from wages, tips | $ | $ | $ |
| Social Security Disability (SSDI) payments | $ | $ | $ |
| Alimony/spousal support received | $ | $ | $ |
| Unemployment benefits | $ | $ | $ |
| Pension/retirement income | $ | $ | $ |
| Rental income you get from property you own and lease | $ | $ | $ |
| Interest income | $ | $ | $ |
| Student financial aid – only include if used for living expenses (scholarships, awards, grants for tuition/education expenses are not counted as income) | $ | $ | $ |
| Other income | $ | $ | $ |
| **TOTAL** | $ | $ | $ |

**Attach copies of the most current proof of income for all the items listed 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
- A bank statement

*(continues)*

## SECTION 4: Household income *(continued)*

**If anyone in your household has income deductions, please complete the table below.**

| Estimated yearly income deductions | Person 1 | Person 2 | Person 3 |
|---|---|---|---|
| Student loan interest | $ | $ | $ |
| Alimony/spousal support you paid | $ | $ | $ |
| Self-employed expenses | $ | $ | $ |
| Other deductions: Please specify | $ | $ | $ |
| **TOTAL** | $ | $ | $ |

**Attach copies of the most current proof of deductions for the items listed above** (examples: student loan statement, copy of alimony check, self-employment receipts).

**Self-employment:** If anyone in your household 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: Certification

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

X _____ Date (mm/dd/yyyy) __/__/____

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

### 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 is called an authorized representative.

Please be sure to provide the name of the same authorized representative you listed on the Kaiser Permanente Application for Health Coverage.

First name _____ MI ____

Last name _____

Organization name (if applicable) _____

Kaiser Permanente entity enrollment number (if applicable) _____ Phone ___-___-____

**By signing, you've appointed this person as your legally authorized representative to get official information about this form, and to act for you on matters related to this form.**

X _____ Date (mm/dd/yyyy) __/__/____

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

In Maryland, Virginia, and the District of Columbia, all plans are offered and underwritten by Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., 2101 East Jefferson St. Rockville, MD 20852

## NONDISCRIMINATION NOTICE

Kaiser Foundation Health Plan of the Mid-Atlantic States, 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 no cost 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 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 **1-800-777-7902** (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: Kaiser Permanente, Appeals and Correspondence Department, Attn: Kaiser Civil Rights Coordinator, 2101 East Jefferson St., Rockville, MD 20852, telephone number: 1-800-777-7902.

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.

In the event of dispute, the provisions of the approved English version of the form will control.

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## HELP IN YOUR LANGUAGE

**ATTENTION:** If you speak English, language assistance services, free of charge, are available to you. Call **1-800-777-7902** (TTY: **711**).

**አማርኛ (Amharic) ማስታወሻ:** የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ **1-800-777-7902** (TTY: **711**).

**العربية (Arabic) ملحوظة:** إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1-800-777-7902** (TTY: **711**).

**Ɓăsɔ́ɔ̀ Wùɖù (Bassa) Dè ɖɛ nìà kɛ dyéɖé gbo:** Ɔ jǔ ké m̀ Ɓàsɔ́ɔ̀-wùɖù-po-nyɔ̀ jǔ ní, nìí, à wuɖu kà kò ɖò po-poò bɛ́ìn m̀ gbo kpáa. Đá **1-800-777-7902** (TTY: **711**)

**বাংলা (Bengali) লক্ষ্য করুনঃ** যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন **1-800-777-7902** (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 **1-800-777-7902**（TTY：**711**）。

**فارسی (Farsi) توجه:** اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با **1-800-777-7902** (TTY: **711**) تماس بگیرید.

**Français (French) ATTENTION:** Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1-800-777-7902** (TTY: **711**).

**Deutsch (German) ACHTUNG:** Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung.
Rufnummer: **1-800-777-7902** (TTY: **711**).

**ગુજરાતી (Gujarati) સૂચના:** જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો **1-800-777-7902** (TTY: **711**).

**Kreyòl Ayisyen (Haitian Creole) ATANSYON:** Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele **1-800-777-7902** (TTY: **711**).

**हिन्दी (Hindi) ध्यान दें:** यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। **1-800-777-7902** (TTY: **711**) पर कॉल करें।

**Igbo (Igbo) NRỤBAMA:** Ọ bụrụ na ị na asụ Igbo, ọrụ enyemaka asụsụ, n'efu, dịịrị gị. Kpọọ **1-800-777-7902** (TTY: **711**).

**Italiano (Italian) ATTENZIONE:** In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero **1-800-777-7902** (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。**1-800-777-7902**（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. **1-800-777-7902** (TTY: **711**) 번으로 전화해 주십시오.

**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 **1-800-777-7902** (TTY: **711**).

**Português (Portuguese) ATENÇÃO:** Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para **1-800-777-7902** (TTY: **711**).

**Русский (Russian) ВНИМАНИЕ:** если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-800-777-7902** (TTY: **711**).

**Español (Spanish) ATENCIÓN:** si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-800-777-7902** (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 **1-800-777-7902** (TTY: **711**).

**ไทย (Thai) เรียน:** ถ้าคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร **1-800-777-7902** (TTY: **711**).

**اُردو (Urdu) خبردار:** اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں **1-800-777-7902** (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 **1-800-777-7902** (TTY: **711**).

**Yorùbá (Yoruba) AKIYESI:** Ti o ba nso ede Yoruba ofe ni iranlowo lori ede wa fun yin o. E pe ero ibanisoro yi **1-800-777-7902** (TTY: **711**).