KAISER PERMANENTE®

Community Health Access Program Subsidy Eligibility Form – 2022

Use this form to apply for a subsidy to pay your monthly premiums and most out-of-pocket costs under the Kaiser Permanente VA Gold 0/20/Vision plan. There is no cost to apply.

Enrollment in Kaiser Permanente's Community 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 Subsidy Eligibility Form

- Type or print using black or blue ink.
- 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 for more examples of proof of income.

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

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

Eligibility rules:

Eligibility for the Kaiser Permanente Community Health 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 an income up to 300% of the federal poverty level.
- Can't be eligible for other public or private health coverage such as, but not limited to, Medicaid, FAMIS, 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 Community Health Access Program.

Step 4: Include additional documents

- Medicaid, FAMIS and/or health benefit exchange denial letters if applicable.
- Other information or documentation that may help us evaluate your eligibility.

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

Send your completed and signed Subsidy Eligibility Form, Kaiser Permanente Application for health coverage, proof of current income, income deductions, and other required documents through one of the following options:

- By email:
  CHC-Applications@kp.org
- By mail:
  California Service Center
  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 Community Health Access Program or about this form, please call us at:

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

Monday through Friday,
7:30 a.m. to 9:00 p.m. Eastern time (closed major holidays).

Please note: Continued eligibility for the Community 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 purposes required by law.

Frequently asked questions

1. **How long does it take to find out if I am approved or denied for Kaiser Permanente's Community Health 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 Community Health Access Program.

2. **How much will I pay each month for the Kaiser Permanente Community 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 Community Health Access Program. You will remain enrolled in the VA Gold 0/20/ Vision plan, but you'll have to pay your full monthly premiums and out-of-pocket costs, unless you ask us to end your membership or until you fail to pay the full premium.

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

5. **What other health coverage programs are available?**
   - **Consider Medicaid or FAMIS.** This option may be available if you were born in the United States, you are a legal permanent resident, and your yearly income is at or below 138% of the federal poverty level ($17,774 for an individual or $36,570 for a family of 4 in 2021). Kaiser Permanente is a Medicaid provider and may be available to you. Please visit kp.org/medicaid/va for more information.
   - **Buy health care coverage through the health benefit exchange.** If you qualify, you may get help paying for your plan premiums or out-of-pocket costs. For more information, visit **HealthCare.gov**.
   - **Call us at 1-800-488-3590 (TTY 711)** or visit **buykp.org** to learn about other Kaiser Permanente for Individuals and Families plan choices.
   - **Consider Medicare,** a federal health insurance 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.

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

This page intentionally left blank

SECTION 1: Applicant information (Required)

Primary applicant

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

First name

MI

Last name

Date of birth (mm/dd/yyyy)

Medical record number (if available)

Gender ☐ Male ☐ Female

Home phone

Mobile phone

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

City

State

ZIP code

Mailing address (Include Apt. Number. If different than home address)

City

State

ZIP code

Email (optional) *I understand I may be contacted via email.*

Please answer **ALL** the questions below about the primary applicant. 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 …

A U.S. citizen? ☐ **Yes** ☐ **No**

A legal permanent resident? ☐ **Yes** ☐ **No**

If Yes, how many years have they been a legal permanent resident? _____

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

SECTION 2: Parent or legal guardian (if applicable)

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

First name

MI

Last name

Date of birth (mm/dd/yyyy)

Gender
☐ Male ☐ Female

Home phone

Mobile phone

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

City

State

ZIP code

Email (optional) *I understand I may be contacted via email.*

SECTION 3: Family information (if applicable)

Spouse to be covered (if applicable)

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

First name

MI

Last name

Date of birth (mm/dd/yyyy)

Medical record number (if available)

Gender
☐ Male ☐ Female

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

Is the spouse …

A U.S. citizen? ☐ Yes ☐ No

A legal permanent resident? ☐ Yes ☐ No

If Yes, how many years have they been a legal permanent resident? _____

Offered health coverage through an employer? ☐ Yes ☐ No

(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 Community Health Access Program subsidy. If an applicant is under 18, the parent or legal guardian should complete this section for the applicant. If you have more than 3 dependents applying, please copy this page and fill out the same information requested below for each additional dependent.

First name

MI

Last name

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

Medical record number (if available)

Gender ☐ Male ☐ Female

Relationship to primary applicant

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

Is the dependent …

A U.S. citizen? ☐ **Yes** ☐ **No**

A legal permanent resident? ☐ **Yes** ☐ **No**

If Yes, how many years have they been a legal permanent resident? _____

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

(continues)

SECTION 3: Family information *(continued)*

Dependent 2 to be covered

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

First name

MI

Last name

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

Medical record number (if available)

Gender ☐ Male ☐ Female

Relationship to primary applicant

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

Is the dependent …

A U.S. citizen? ☐ Yes ☐ No

A legal permanent resident? ☐ Yes ☐ No

If Yes, how many years have they been a legal permanent resident? _____

Offered health coverage through an employer? ☐ Yes ☐ No

Dependent 3 to be covered

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

First name

MI

Last name

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

Medical record number (if available)

Gender ☐ Male ☐ Female

Relationship to primary applicant

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

Is the dependent …

A U.S. citizen? ☐ Yes ☐ No

A legal permanent resident? ☐ Yes ☐ No

If Yes, how many years have they been a legal permanent resident? _____

Offered health coverage through an employer? ☐ Yes ☐ No

SECTION 4: Household income (Required)

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

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

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

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

(C) Please complete the table below.

- List the estimated yearly gross income (before taxes) for each family member counted in (B).
- If (B) is more than 3, make a copy of this page, provide the same information for each additional family member, and send it with your application.
- For child dependents who are working but whose income is below the threshold required for filing taxes ($12,400 in 2020):
  - 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 gross income (before taxes)	family member 1	family member 2	family member 3
Gross 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	$	$	$

Please tell us about any special circumstances about your work and income. For example, I only work part of the year and my spouse works all year, I changed jobs or work hours during the year, etc.: _____

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

- Pay stubs
- Award letters for Social Security or unemployment benefits
- 1040 tax form from previous year
- W-2 from current employer
- Letter from employer
- A bank statement that indicates your payroll direct deposit or wages. Please note on the statement which items apply.

We will calculate the total income by adding up the proof of income documents. If your proof of income doesn't match the yearly gross income table above, please explain in the space provided above.

(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: Choose an authorized representative (if you have one)

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

First name

MI

Last name

Organization name (if applicable)

Kaiser Permanente entity enrollment number (if applicable)

Phone

By signing, you've appointed this person or community partner/agency as your legally authorized representative to get information for this Kaiser Permanente form and to act for you on matters related to this form. This authorization lasts 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 California Service Center, 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 it to your representative, your information may be redisclosed by your representative and no longer protected by federal privacy law. Even if you don't sign this authorization, we will still process your application for the Community Health 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 6: Sign the Subsidy Eligibility Form (Required)

By signing this form, you certify the information on this form is correct and accurate. If you provide incorrect or incomplete information on this form or in further correspondence concerning this form, any Kaiser Permanente subsidy to cover costs related to health coverage may be terminated. Membership approval for Kaiser Permanente's Community Health 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)

All plans are offered and underwritten by Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., 2101 East Jefferson St., Rockville, MD 20852.


KAISER PERMANENTE®

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.

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-poɔ̀ bɛ́ìn m̀ gbo kpáa. Ɖá **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**).