Kaiser Permanente Community
Health Coverage Program - Virginia

Instructions for completing the Reapplication for Subsidy Form

This document tells you how to complete the Community Health Coverage Program (CHCP) Reapplication for Subsidy Form when reapplying for the Kaiser Permanente Community Health Coverage Program.

What you need to do:

- **Complete the form**, including proof of income and other required documents if applicable.
- **Submit the completed form** by October 1, 2025.
- **Make a copy** of your completed form for your records.
- **Send your documents** in one of these ways:

By email: CHC-Applications@kp.org

- Include the word "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

- Be sure to save the fax confirmation page.

We're here to help

If you have any questions, please call Member Services at **1-800-777-7902** (TTY **711**), Monday through Friday, 7:30 a.m. to 9:00 p.m. Eastern time (closed major holidays).

If a KP CHCP Navigator helped you with your reapplication, you can contact them with questions. Visit **kp.org/mas-chap/gethelp** to find your KP CHCP Navigator.

KAISER PERMANENTE.

Community Health Coverage Program (CHCP) Reapplication for subsidy – 2026

Reminder: Make sure the 2026 version of the form is being used

Use this form to reapply for a subsidy to pay your monthly premiums and most out-of-pocket costs under the KP VA Gold 0 Ded/500 RxDed/Vision plan. There is no cost to reapply.
To reapply, follow these steps:

Step 1: Reapply by the deadline

To reapply for the Community Health Coverage Program (CHCP), we **must** receive this form by **10/1/2025**. If we do not receive this form by this date, you'll no longer get financial help, and will have to pay the full monthly premium and out of pocket costs, starting January 1, 2026.

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.

Be sure to make a copy of the reapplication 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

- Live in the ... 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.
- Not eligible for other public or private health coverage such as, but not limited to, Medicaid, FAMIS, Medicare, an affordabl... benefit exch...
- In most case... dependents ... younger than 26.
- The primary applicant and applying adult(s) 21 years and older are eligible for the CHCP subsidy for up to a maximum of 3 consecutive years, as long as each continues to meet the CHCP eligibility requirements.

You do NOT have to be a U.S. citizen to be eligible for CHCP.

Step 4: Include additional documents

- Medicaid or FAMIS and/or Virginia's Insurance Marketplace 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, 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:

- 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

Email is highly encouraged and the preferred method for submission. Please ensure you include the word "**application**" in the subject line when emailing your application and supporting documents.

We're here to help:

If you have questions about CHCP or about this form, please call us at:

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

Monday t
a.m. to 9:
(closed m

Commu
Partner i

Contact y
Navigator
Visit **kp.o**

Please note: Continued eligibility for CHCP 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 CHCP?**
   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 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 CHCP. You will remain enrolled in the KP VA Gold 0 Ded/500 RxDed/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 Virginia's Insurance Marketplace. Can I still qualify for CHCP?**
   Not being able to pay Virginia's Insurance Marketplace premiums does not qualify you for CHCP. You must meet the CHCP income and other criteria to qualify.

5. **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 2025, the threshold that determines if an employer plan is affordable is if the premium is equal to or less than 9.02% of one's household income. If you believe your job-based coverage is unaffordable, please submit proof of job-based coverage and include information on the cost of coverage and frequency of payment.

6. **What other health coverage programs are available?**
   Find out if you qualify for Medicaid or Family Access to Medical Insurance (FAMIS) program for children. 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 in households with income at or below 148% of the Federal Poverty Level (FPL) ($23,162 for an individual or $47,582 for a family of 4 in 2025).
   - Adults 19 - 64 with household income up to 138% of the FPL ($21,597 for an individual or $44,367 for a family of 4 in 2025). Kaiser Permanente is a Medicaid provider and may be available to you.
   - Pregnant individuals with income up to 148% of the FPL ($23,162 for an individual or $47,582 for a family of 4 in 2025).

   FAMIS Prenatal Coverage and FAMIS MOMS Program

   - Pregnant individuals with income up to 205% of FPL ($23,162 for an individual or $47,582 for a family of 4 in 2025). The FAMIS Prenatal Coverage program is available regardless of immigration status.

   For more information please visit **kp.org/medicaid/va**.

   Buy health care coverage through Virginia's Insurance Marketplace. If you qualify, you may get help paying for your plan premiums or out-of-pocket costs. Remember to enroll during Virginia's Insurance Marketplace's 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 **buykp.org**.

   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 Medicaid. Please visit **kp.org/medicaid/va** to learn more.

7. **Is CHCP a public benefit that could impact my ability to become a lawful permanent resident or U.S. citizen in the future?**

   No, CHCP 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.

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 may apply during Open Enrollment by submitting a new application. Call us at **1-800-777-7902** (TTY **711**) for information on submitting a new application during Open Enrollment. All current members will keep their CHCP subsidy until 12/31/2025.

SECTION 1: Member information (Required)

Primary member

The person who is covered by the he
If reapplying for a child under 18, com
complete section 2 with the parent

To ensure accurate processing, include the MRN/HRN found on the member ID card or through kp.org

First name* J a n e

R

Last name* S m i t h

Date of birth* (mm/dd/yyyy) 0 8 / 0 7 / 1 9 8 0

Medical record number (if available) 5 8 5 6 2 5 1

Gender* ☐ Male ☒ Female

Reminder: Include Apt # or Suite # and validate address with member

Home phone - -

Mobile phone 7 0 3 - 4 6 7 - 7 8

Home address* (Include Apt. Number. No P. O. boxes, please) 1 2 3 4 M a i n S t r e e t

City* A l e x a n d r i a

State V

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

City

State

Email j a n e . s m i t h @ g m a i l . c o m

Providing a phone number and email address is HIGHLY encouraged in case the application processing team has questions about the form

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 an employer?* ☐ Yes ☒ No

A U.S. citizen?*
If you answered yes, skip the following two questions.

A Lawful Permanent Resident[1]?

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

Eligibility questions must be answered; if you indicate "Yes" for US Citizen, skip the last two questions

*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 | Phone ___ - ___ - ___

Mailing address (Include Apt. Number. P.

City | State | ZIP code

Email

This section is only applicable if an adult is applying for a minor (child under 18). Eligibility will not be assessed for anyone listed in this section and they will not receive an approval or denial letter.

SECTION 3: Family information (if applicable)

Spouse (if applicable)

Please complete this section f...
in section 1 is an adult and is seeking coverag...

Only complete this section if you currently have a spouse/domestic partner enrolled in the plan

First name

Last name

Medical record number (if available)

Gender ☐ Male ☐ Female

To ensure accurate processing, include the MRN/HRN found on the member ID card or through kp.org

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

Is the spouse...

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]?

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

Eligibility questions must be answered; if you indicate “Yes” for US Citizen, skip the last two questions

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

SECTION 3: Family information *(continued)*

Dependent 1

Please complete this section for each additional d
plan and reapplying for the CHCP subsidy. Only co
applicant listed in section 1 is an adult and is seek
OR if ...
has additional minors seeking

If you have more than 3 dependents reapplying
same information requested below for each add

Only complete this section if you have a dependent(s) currently enrolled in the plan. If you have more than 3 dependents repplying, 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)

Male Female

To ensure accurate processing, include the MRN/HRN found on the member ID card or through kp.org

Please answer **ALL** applicable questions below about the dependent. This inf
dependent is eligible for CHCP 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]

Eligibility questions must be answered; if you indicate "Yes" for US Citizen, skip the last two questions

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 CHCP subsidy. Only complete this section if the primary applicant listed in ... 1 is an adult and is seeking coverage for additional dependents, OR if applicant ... 1 is a minor and the paren... ...) has additional minors seeking ...

Only complete this section if you currently have a dependent(s) currently enrolled in the plan

First name

Last name

Date of birth (mm/dd/y... / /

Medical record number (if available)

Gender ☐ Male ☐ Female

Relationship to primary member

To ensure accurate processing, include the MRN/HRN found on the member ID card or through kp.org

Please answer **ALL** applicable questions below about t... dependent is eligible for CHCP or other programs that prov...

Is the dependent ...

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

A U.S. citizen? ... ☐ 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

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 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 ...

Relationship to primary member

To ensure accurate processing, include the MRN/HRN found on the member ID card or through kp.org

Please answer **ALL** applicable questions below about the dep... dependent is eligible for CHCP or other programs that provid...

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]?

Eligibility questions must be answered; if you indicate "Yes" for US Citizen, skip the last two questions

1. A Lawful Permanent Resident (LPR) is not a U.S. citizen. An LPR is an immigrant who resides in the U... status. Examples include Green Card Holders, Permanent Resident Aliens, Deferred Action for Chil... Permit Holders.

SECTION 4: Household income (Required)

Reminder: Only include family members that are or would be included on your tax form

Your family size, household income, and proof of income documents help us determine if you quali
yearly household income, we'll add up the amounts shown in your proof of income docume

(A) How many family members† live in your household?* 3

†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?* 1

Don't include working child dependents (18 and younger, or up … ax-filing threshold ($14,600 in 2025). Don't submit proof of income documents for

This question MUST be answered, even if it is "0"

☐ I do not work / No one in my household works

(C) Attach copies of the most current proof of income for E… o household income.

If your household DOES NOT have proof of income, check the box below and fill in the blank with monthly household income.

☒ I attest that I have no proof of income. My monthly household gross income is $ 6,500

Complete this section if you DO NOT have proof of income documentation. Please provide your monthly gross income amount.

If your household has proof of income, please submit documentation for the income you receive

Qualifying income and relevant examples are below:

Wages and/or tips:	Your last 2 paycheck stubs, W-2 from employer, or last year's 1040 tax form. No 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 (the adjusted gross income page)
Social security payments:	Award letters for social security and Social Security Disability Insurance (SSDI) pay
Unemployment benefits	Award letters for unemployment benefits
Alimony received	Submit court documents or a letter from your former spouse detailing paymen information.(only if your divorce or separation was finalized before January 1, 20
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	

If you have income that varies by month, such as tips, overtime, or commissions, check the box below and fill in the blank with the estimated total gross income in 2025 from variable wages.

☐ I attest that I have income that varies by month. My total expected gross income in 2025 from variable income is $__________

Include the total amount received so far this year and estimate the expected amount for the rest of the year.

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

Complete this section if you have income that varies. Please provide the total annual expected gross variable income amount for 2025.

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

(cont

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

Qualifying Deductions:

- **Self-employed expenses:** Only if subm ... fit and loss form. If submitting a schedule C of last year's federal income tax return, we will review the adjusted gross ...
- **Alimony you pay:** Submit court documents or a letter from your ... 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 f...
- **IRA contributions:** Submit your Form 5498 from the most recent tax year. (if you don' ... 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)

If you have qualifying deductions, please provide documentation

SECTION 5: Options if you're not eligible

If you no longer meet the eligibility requirements, you will be disenrolled from CHCP, but remain enrolled in the KP VA Gold 0 Ded/500 RxDed/Vision plan. You must begin to pay your full monthly premiums and out-of-pocket costs, unless you end your membership or until you fail to pay the full premium. However, you can cancel your 2026 KP VA Gold 0 Ded/500 RxDed/Vision plan coverage below if you're not eligible for CHCP.

If you no longer meet the CHCP eligibility requirements an... Vision plan, please check the box b...

☒ Disenroll all individuals on my plan from the the KP VA Gol... 2025, if they no longer meet the CHCP eligibility requireme...

If you don't check the box and if your reapplication is not approve... but you'll be responsible for the full monthly premium and out-o... early December 2025. If you have questions, call us at **1-800-777**...

You also have the option of submitting a request in writing or ca... Gold 0 Ded/500 RxDed/Vision plan. Contact us by November 30, 2025 to avoid receiving your first bill.

If this option is left blank and the member is determined ineligible for the subsidy, the member will remain enrolled in the KPIF plan but will be responsible for the premium starting in 2026. The member will be advised of the renewal plan cost by mail in October or November.

SECTION 6: Community Partner Verification

Organization name

Organization phone ___-___-___ Phone extension (if ap...

Organization email address

Community partner representative

If a community partner assists with the Reapplication form, please complete this section

I attest that I assisted the applicant(s) with this application for 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 ______________________ Date (mm/dd/yyyy) __/__/____

Signature of community partner repr...

The community partner representative's signature is required

SECTION 7: Choose an authorized representative (if you have one)

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

First name

Last name

Organization name (if applicable)

Phone

___ - ___ - ____

An Authorized Representative is only for the purpose of assisting with this form. If you'd like to have your community partner be your authorized representative to assist you if there are any questions about the reapplication form, they must be listed here in addition to Section 6.

By signing, you've appointed this person or community partn

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 und

The primary member is required to sign if an authorized representative is provided

This authorization lasts one (1) year from your signature date **tion at any time by submitting a signed written request to Kaiser Per** **A 92193-9095 or fax: 1-855-355-5334. Once you cancel, we w** **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 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

The primary member is required to sign if an authorized representative is provided

SECTION 8: Sign the reapplication agreeme

By signing this form, you certify the information on this form is corre information on this form or in further correspondence concerning th related to health coverage may be terminated. Membership approval for CHCP is not guaranteed as it is based on eligibility and availability.

X Jane Smith

Digitally signed by: Jane Smith
DN: CN = Jane Smith email = jane.smith@gmail.com C = AD
Date: 2025.07.18 20:50:27 -04'00'

Date (mm/dd/yyyy)

08 / 01 / 2025

Primary applicant (parent or legal guardia n und

The primary member's signature is required

All plans are offered and underwritten by Kaiser Foundation H 4000 Garden City Drive, Hyattsville, MD 20785.