



KAISER PERMANENTE

Medical Financial Assistance Program (MFAP) and Discount Payment Program

If you need help paying for your medical services, you may be eligible for Kaiser Permanente’s Medical Financial Assistance Program or Discount Payment Program. Use this brochure to help determine if you qualify, as well as to apply for financial assistance.

The MFAP and the Discount Payment Program are discretionary programs offered by Kaiser Permanente to all patients for services that are medically necessary. Services must be received at a Kaiser Permanente hospital or physician’s office, and from a Kaiser Permanente provider. You also must apply within six months of when you received the services you’re applying for.

The MFAP may help pay for the full cost of, or the copayment amount for, medications you receive at a Kaiser Permanente pharmacy. If you’re covered under Medicare Part D and don’t already receive a Limited Income Subsidy (LIS) discount from Medicare, you can apply for a pharmacy waiver using this application.

Applying for the Medical Financial Assistance Program (MFAP)

You must meet the following criteria to be eligible for the MFAP:

Other Payer Sources—Concurrent with your application to the MFAP, you must apply for any private or public sector sources of medical financial assistance for which you’re eligible, such as Medi-Cal or Healthy Families. You may be required to submit documentation of your application (or of the approval or denial of your application) to those sources. You may qualify for an MFAP award while waiting for a decision regarding your eligibility for these other programs.

Income—Your household income must be at or below 350 percent of the Federal Poverty Guidelines (FPG). If you don’t qualify for the MFAP and your income is at or below 400 percent of the FPG, you may be eligible for the Discount Payment Program.

Types of Care—You must be receiving medically necessary care and all services must be billed by a Kaiser Permanente hospital or medical provider.

Special Circumstances—If you have unusually high medical costs or you’ve experienced a catastrophic event, you may be eligible for the MFAP under special circumstances, regardless of whether you meet the household income requirements described above. To qualify, you’ll need to provide income documentation and copies of your out-of-pocket medical expenses for the past 12 months indicating that these expenses equal 10 percent or more of your annual gross income.

You **must** apply under special circumstances if:

- You’re a member of a Kaiser Permanente deductible HMO plan.
- You’re applying for durable medical equipment or access to a skilled nursing facility (in which case, a referral from a Kaiser Permanente physician is also required with your application).

Please note: Not all medical expenses qualify for financial assistance under the MFAP. Exclusions include, but aren’t limited to, expenses for premiums and dues, non-Kaiser Permanente services, lifestyle services, optical and hearing aids, medical supplies or soft goods, fee-for-service or venture services, health education classes, transportation, over-the-counter drugs, brand medications when generics exist, and lifestyle medications (fertility, cosmetic, etc.).

Documentation required:

- A copy of a current pay stub with year-to-date (YTD) income included. If YTD income is not listed, then copies of two consecutive pay stubs; **or**
- A copy of your most recent federal tax return, with electronic submission verification or your signature (include all pages and schedules); **or**
- Copies of other documents to verify income, such as letters from disability, Social Security, unemployment agencies, or proof of alimony/child support payments; **or**
- If you have no income, a letter of support that explains your means of living; **and**
- Any other documentation that may be requested.

If your family size is:	Your annual income at 300% of FPG is equal to:	Your annual income at 350% of FPG is equal to:	Your annual income at 400% of FPG is equal to:
1	\$32,670	\$38,115	\$43,560
2	\$44,130	\$51,485	\$58,840
3	\$55,590	\$64,855	\$74,120
4	\$67,050	\$78,225	\$89,400

Be sure to send only photocopies, as originals will not be returned to you. You'll have an opportunity to appeal the decision if your application is denied. Corrected and/or additional documentation will be required to support your appeal request.

The MFAP may include waivers by Kaiser Permanente pharmacies of member cost sharing for medications covered under Medicare Part D.

Applying for the Discount Payment Program

You must meet the following criteria to be eligible for the Discount Payment Program:

- You must be uninsured and ineligible for all other public programs, such as Medi-Cal and Healthy Families.
- Your household income must be between 351 and 400 percent of the Federal Poverty Guidelines (FPG).
- You must be receiving medically necessary care and all services must be provided by a Kaiser Permanente hospital or medical provider.
- You must meet all documentation requirements listed in the "Applying for the Medical Financial Assistance Program (MFAP)" section of this brochure.

Kaiser Permanente reserves the right to amend or retract awards.

Submit your application to:

Medical Financial Assistance Program and Discount Payment Program

PO Box 30006
Walnut Creek, CA 94598

Phone: **1-866-399-7696**

Fax: **1-800-687-9901**

Hours: Monday–Friday, 8 a.m.–5 p.m.

Help in Your Language

Interpreters are available 24 hours a day, seven days a week, at no cost to you. We can also provide you, your family, and your friends with any special assistance needed to access our facilities and services. In addition, you may be able to get materials written in your language. For more information, call our Member Service Call Center at **1-800-464-4000**, weekdays from 7 a.m. to 7 p.m. and weekends from 7 a.m. to 3 p.m. For TTY service for the deaf, hard of hearing, or speech impaired, call **1-800-777-1370**.

Ayuda en su propio idioma

Tenemos disponibles intérpretes 24 horas al día, 7 días a la semana, sin ningún costo para usted. También podemos ofrecerle a usted, sus familiares y sus amigos cualquier tipo de ayuda que necesiten para tener acceso a nuestras instalaciones y servicios. Además, usted puede obtener materiales escritos en su idioma. Si desea obtener más información comuníquese con nuestra Central de Llamadas de Servicio a los Miembros al **1-800-788-0616**, de 7 a.m. a 7 p.m. entre semana, y de 7 a.m. a 3 p.m. los fines de semana. Las personas sordas, con problemas auditivos o del habla, pueden comunicarse con el servicio TTY llamando al **1-800-777-1370**.

語言翻譯協助

提供每週七天,每天廿四小時翻譯。我們也向會員及其親友提供利用我處設施及服務所需之任何協助。此外會員還可索取以其母語編寫的資料。欲獲得更多資訊,請致電我們的會員服務電話中心 **1-800-757-7585**,週日上午7點至晚上7點、週末上午7點至下午3點。失聰、有聽力和語言障礙者請用打字電話致電 **1-800-777-1370**。

Application

APPLICANT(S)

Patient name:* _____

Medical record number:* _____

Address:* _____

City, State, ZIP:* _____

Social Security number: _____

Phone number:* _____

Date of birth:* _____

Marital status: Married Divorced Widow(er) Single Domestic partner

Does your spouse or domestic partner need to be considered for financial assistance? Yes No

Spouse/domestic partner information:

Patient name:* _____

Medical record number:* _____

Social Security number: _____

Date of birth:* _____

Household size (including yourself, your spouse or domestic partner, and all dependents):* _____

List all household members you financially support:* (Check the box next to the name of any dependents who need to be considered for financial assistance.)

Dependent's name _____

Date of birth _____ Relationship _____

Medical record number _____ Social Security number _____

Dependent's name _____

Date of birth _____ Relationship _____

Medical record number _____ Social Security number _____

Dependent's name _____

Date of birth _____ Relationship _____

Medical record number _____ Social Security number _____

Medical facility where you get your services:* _____

Employment status:*

Currently employed? Yes No

Spouse/domestic partner employed? Yes No

SECTION D: LOW INCOME SUBSIDY (LIS) SCREENING (Only required if you are a Medicare Part D beneficiary.)

If you're a Medicare Part D beneficiary with limited income and resources, you may qualify for extra help paying for your prescription drug costs. LIS provides financial assistance for eligible Medicare Part D beneficiaries who need help paying for their monthly premium, yearly deductible, prescription coinsurance and copayments, and related medical expenses.

- Are you enrolled in a Medicare savings program (QMB, SLMB, QI) where the state pays for Medicare premiums? Yes No
- Is your annual income \$16,245 or less if you're single or \$21,855 or less if you're married and living with your spouse? Yes No
- Do your resources or assets (e.g., savings accounts or investments) total less than \$12,640 if you are single or \$25,260 if you're married and living with your spouse? Yes No

If you've already applied for Medicare LIS and you have a recent denial or pending letter, please submit a copy with your MFA application.

SECTION E: MISSING INCOME DOCUMENTATION

If you don't have income documentation, your signed attestation in this application may satisfy the income verification requirement if you meet any of the following criteria:

- I don't receive a formal pay stub from my employer.
- I receive no income. (If you check this box, you must provide a written explanation of your financial situation.)
- I wasn't required to file a recent Federal or State Tax Return for the most recent tax year.

SECTION F: Financial Agreement and Credit Report Authorization (Signature required.)

I hereby declare under penalty of perjury that (i) all information set forth above in this application is true and accurate in all respects, and that all attachments are accurate copies of the original documents, or (ii) I am unable to provide documents relating to proof of income or other evidence of my income. I authorize employees and agents of Kaiser Foundation Health Plan, Inc. (KFHP) and/or its affiliates to investigate and verify that information I have provided to it, including employment and credit history, for the purpose of determining my eligibility to participate in the Medical Financial Assistance Program and Discount Payment Program (together, the "Program"). I also acknowledge and agree that I am liable to KFHP for any and all amounts owing to KFHP for medical goods and services that are not covered by the Program (the "Remaining Amounts").

In case of joint signature below, we each make the promises, representations, and authorizations set forth in the previous paragraph, including authorization and consent for employees and agents of KFHP to investigate and verify our individual and joint credit and employment histories. We also acknowledge and agree that we are each jointly and severally liable to Kaiser Permanente for the Remaining Amounts (that is, we shall each owe the Remaining Amounts to KFHP, and KFHP may collect from either or both of us an amount which does not, in total, exceed the Remaining Amounts).

Signature of Applicant/Guardian _____ Date _____

Signature of Spouse of Applicant/Guardian _____ Date _____

Upon finalization of your application, notification of your determination will be mailed to the address on file.

