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Kaiser Permanente Medical Financial Assistance (MFA) Program

If you can't pay for medical care, the Kaiser Permanente Medical Financial Assistance (MFA) program may be able to help. Our MFA program offers financial help to those who qualify. If you meet the requirements listed below, you'll need to fill out and send this application to participate in the program – unless you've already been pre-screened as being eligible. Please note: The MFA program is available to all Kaiser Permanente patients, whether or not you're a Kaiser Permanente member. Help is available for emergency or medically needed care only. If you qualify, medical services and prescriptions need to be ordered by a Kaiser Permanente provider at a Kaiser Permanente facility.

Step 1

QUALIFICATION REQUIREMENTS

You must meet one of the following to qualify for medical financial assistance:

☐ Your gross household income must be no more than 350% of the Federal Poverty Guidelines. Visit **aspe.hhs.gov/poverty** to find the poverty guideline for your state.

☐ Your out-of-pocket medical expenses are more than 10% of your annual gross household income.

Special circumstances. If you have unusually high medical costs, you may be eligible for the MFA program if your out-of-pocket costs over a 12-month period are equal to or more than 10% of your annual gross household income. Out-of-pocket medical costs include copays, coinsurance, and deductible payments for emergency or medically needed services, as well as dental care and prescription medication. We may ask you to give proof of income or copies of your out-of-pocket medical or dental expenses.

Not all medical expenses qualify. For example:

- Amounts you pay for health plan premiums
- Services you get at a non–Kaiser Permanente provider
- Non-emergency elective or lifestyle services that aren't considered medically necessary
- Specifically excluded drugs, like fertility, cosmetic, or non-formulary medications
- Over-the-counter drugs or supplies

For more information about qualifying for the MFA program, or to find out more about which services are covered, please see the MFA policy for your Kaiser Permanente area.

Step 2

INSTRUCTIONS

If you meet the eligibility requirements, please mail or fax your signed, completed application with all appropriate supporting documentation to Kaiser Permanente Medical Financial Assistance Program, PO Box 7086, Pasadena, CA 91109-7086, FAX 1-866-497-0005, www.kp.org/mfa/scal.

Questions? If you have any questions or if you need help with this application, please call **1-866-399-7696** or **1-800-777-1370** (TTY for the hearing/speech impaired), Monday through Friday, 8:00 a.m. to 5:00 p.m. PST. You can also talk to a patient financial advisor at a Kaiser Permanente location near you.

Notification of our decision. After we receive your completed application, we'll let you know our decision by mail or phone. This will include an explanation of your approval or denial. If approved, your award will depend on your income level and medical expenses. If you're denied, you'll have an opportunity to appeal the decision. In some cases, we may ask for corrected or additional information.

You may also need to apply for public or private health coverage. When you apply to the MFA program, you may also need to apply to any public or private health programs you're eligible for. These may include Medi-Cal or the Health Insurance Marketplace. For more information, visit **healthcare.gov** or call **1-800-318-2596**. We may ask you to show us proof you've applied to these programs or that you've been approved or denied. You may qualify for an MFA award while waiting for a decision from these programs.

Please be sure to complete the application as completely as you can. Any missing information may delay any award you might get.

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Step 3

Please complete the information below.

PATIENT

Name (first name, middle initial, last name)		Birth date (mm/dd/yyyy)
Street address		Apt. number
City, State, ZIP		
Home/cell phone	Medical record number	Social Security number
Spouse/guardian name (first name, middle initial, last name)		Birth date (mm/dd/yyyy)
Home/cell phone	Medical record number	Social Security number

INFORMATION

Are you or a family member in your household currently employed? ☐ Yes ☐ No

Do you have any other medical insurance? If yes, with whom: ☐ Yes ☐ No Subscriber ID number: _____

Insurance company name: _____

Do you have Medicare? ☐ Yes ☐ No If yes, list your Subscriber ID number: _____

Are you enrolled in a Medicare savings program where the state pays for Medicare premiums? ☐ Yes ☐ No

Are you enrolled in a Medicare Part D? ☐ Yes ☐ No

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 through the Low Income Subsidy (LIS).

Have you already applied for Medicare LIS with Social Security Administration? ☐ Yes ☐ No

If yes and you have a recent approval, denial or pending letter, please submit a copy with your MFA application.

Do you have or have you applied for Medi-Cal? ☐ Yes ☐ No ☐ Unsure

If yes, list your Subscriber ID number: _____

If you've already applied for Medi-Cal and have a recent approval or denial or a pending letter, please send a copy with your completed MFA application.

Do you have a Health Savings Account with a current balance? ☐ Yes ☐ No

FAMILY HOUSEHOLD/DEPENDENTS

Family Household Size: _____ (List the number of family members who live with you in your home, such as a spouse, a qualified domestic partner, children, non-parent caretaker relatives, etc.)

a. Dependent name: (only if applying for MFA)

Relationship	Medical record number	Birth date (mm/dd/yyyy)

b. Dependent name: (only if applying for MFA)

Relationship	Medical record number	Birth date (mm/dd/yyyy)

c. Dependent name: (only if applying for MFA)

Relationship	Medical record number	Birth date (mm/dd/yyyy)

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Incomplete information will result in a delay in processing or denial of your MFA application.

MONTHLY GROSS FAMILY INCOME (List ALL Income from family members in the household)

Applicant/patient		Spouse/guardian	
Gross Salary/Wages (before taxes)	$	Gross Salary/Wages (before taxes)	$
Alimony/Child support	$	Alimony/Child support	$
Self-employment or Business income*	$	Self-employment or Business income*	$
Pension or retirement/Annuities	$	Pension or retirement/Annuities	$
Unemployment benefits	$	Unemployment benefits	$
Social Security/state disability/temporary disability/ supplemental security income/veterans benefits	$	Social Security/state disability/temporary disability/ supplemental security income/veterans benefits	$
Rental property	$	Rental property	$
Other, including cash income (describe):	$	Other, including cash income (describe):	$
Total monthly income	**$**	**Total monthly income**	**$**

*When reporting rental or self-employment income, include your most recent tax return, along with all supporting schedules.

PROOF OF INCOME DOCUMENTATION

Important: You may need to provide us with ***copies*** of the following documents for all applicants.

- A copy of your most recent signed federal tax return or W-2, with electronic submission verification or your signature (including all pages and schedules)
- A copy of your 2 most recent pay stubs showing year-to-date (YTD) income
- Copies of other recent documents, income-generating statements or award letters to verify additional household income, such as:
  - Disability
  - Unemployment
  - Proof of alimony/child support payments
  - Rental or estate income
  - Social Security
  - Bank statements
  - Retirement or pension accounts

Please do not send originals. Only copies are needed.

Please note: If we're able to verify your financial status using external data sources or third-party vendors, then you do not need to send us the documentation listed above.

OTHER INCOME DOCUMENTATION

If you don't have documentation to verify your income AND you meet any of the following criteria, please include a signed statement that explains your income situation.

☐ I do not receive a formal pay stub from my employer.

☐ I have no income. (If you check this box, you must provide a written explanation of your financial situation in the "Income" section of this application.)

☐ I was not required to file a federal or state tax return for the most recent tax year.

If none of the above apply, you may need to submit copies of all required documents with this application.

MEDICAL EXPENSES – SPECIAL CIRCUMSTANCES

If your household income is equal to or more than 350% of the Federal Poverty Guidelines or if you're applying under special circumstances, you must complete this section. Please list your out-of-pocket medical expenses paid within the last 12 months and submit copies of your non–Kaiser Permanente receipts or itemized invoices with your completed MFA application.

Hospital or office visits: $ _____ Prescribed medications: $ _____

Other medical expenses, such as ambulance services, medical equipment, or dental expenses: $ _____

(please describe):

FINANCIAL AGREEMENT AND CREDIT REPORT AUTHORIZATION

I hereby declare under penalty of perjury that (a) 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 (b) I am unable to provide documents relating to proof of income or other evidence of my income. I also acknowledge and agree that I am liable to Kaiser Foundation Health Plans (KFHP) for any and all amounts owing to KFHP for medical goods and services that are not covered by the Program (the "Remaining Amounts").

☐ I agree to let Kaiser Foundation Health Plans and Kaiser Foundation Hospitals obtain information from consumer credit reporting agencies and other third-party information sources to determine my eligibility for federal, state, and private medical programs.

☐ I do not agree to what's described in the previous sentence. (Please initial here if you checked this box.) _____

Applicant or account holder will be notified, by mail or phone, whether the application is approved or denied. Kaiser Permanente reserves the right to amend or retract awards.

Signature of Applicant/Guardian	Date (mm/dd/yyyy)
X	
Signature of Spouse of Applicant/Guardian	Date (mm/dd/yyyy)
X	

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HELP IN YOUR LANGUAGE

Interpreters are available 24 hours a day, 7 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** or **1-800-777-1370** (TTY for the deaf, hard of hearing, or speech impaired), weekdays from 7 a.m. to 7 p.m. and weekends from 7 a.m. to 3 p.m.

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。若需更多資訊，請於週一至週五上午七時至下午七時及週末上午七時至下午三時致電會員服務電話中心，電話號碼為 **1-800-757-7585** 或 **1-800-777-1370**（聽障專線）。