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Kaiser Permanente Medical Financial Assistance (MFA) Program

HELP IN YOUR LANGUAGE

English: This is important information from Kaiser Permanente. If you need help understanding this information, please call **1-800-464-4000** and ask for language assistance. Help is available 24 hours a day, 7 days a week, excluding holidays.

Chinese: 這是來自Kaiser Permanente的重要資訊。如果您需要協助瞭解此資訊，請致電**1-800-757-7585** 尋求語言協助。我們每週7天，每天24小時皆提供協助（節假日休息）。

Spanish: La presente incluye información importante de Kaiser Permanente. Si necesita ayuda para entender esta información, llame al **1-800-788-0616** y pida ayuda linguística. Hay ayuda disponible 24 horas al día, siete días a la semana, excluidos los días festivos.

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Please recycle. January 2019

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Kaiser Permanente Medical Financial Assistance (MFA) Program

If you need help paying for health care services or prescriptions you've gotten, or are scheduled to get, from Kaiser Permanente, our MFA program may be able to help you.

How the program works

- The program offers temporary "awards" to help qualified applicants pay for care based on their financial needs.
- It's available to all Kaiser Permanente patients, whether you're a member or not.
- If awarded, the program will cover emergency or medically necessary care from Kaiser Permanente providers or at Kaiser Permanente facilities for a specified time period.

How to qualify

You must meet one of the following eligibility requirements:*

1. Your gross household income is no more than 350% of the federal poverty level.

*__Note:__ If your gross household income is more than 350% of the federal poverty level and/or you're a Kaiser Permanente member with a deductible plan in California, you must meet the criterion below.

2. Your out-of-pocket health care costs for emergency or medically necessary care, dental care, and medication over a 12-month period are equal to or more than 10% of your gross household income.

   Out-of-pocket costs include copays, coinsurance, and deductible payments.

   Out-of-pocket costs do not include any payments for your health plan itself, like your monthly premium.

350% of federal poverty level guidelines

If your household size is:	Your household income must be no more than:	
	Monthly	Annually
1	$3,643	$43,715
2	$4,932	$59,185
3	$6,221	$74,655
4	$7,510	$90,125
5	$8,800	$105,595
6	$10,089	$121,065

Visit **aspe.hhs.gov/poverty** to find the guidelines for larger households.

Have questions?

For more information about qualifying for the MFA program, or to see which health care services it pays for, visit **www.kp.org/mfa/ncal**.

If you don't have health insurance, you may be required to apply for it.

- Because the MFA program only provides temporary financial awards, we may require you to apply for coverage that will cover you in the long term. This could include any other public or private health programs you're eligible for — like Medi-Cal or subsidized plans available on the health insurance marketplaces.
- We may ask you to show proof that you've applied to these programs, or that you've been approved or denied by them. But you may still be able to get financial help from the MFA program while waiting for a decision from these other programs.
- For more information about other health coverage you may be eligible for, visit **healthcare.gov** or call **1-800-318-2596.**

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How to apply

If you meet the eligibility requirements, you can apply in any of these ways.

 **Mail it**	• Complete the MFA application on the following page. • Mail your completed application to: Kaiser Permanente MFA Program PO Box 30006 Walnut Creek, CA 94598
 **Fax it**	• Complete the MFA application on the following page. • Fax your completed application to **1-800-687-9901.**
 **Drop it off**	• Complete the MFA application on the following page. • Drop off your completed application at the Patient Financial Operations at any Kaiser Permanente facility.
 **Call us**	• Call us at **1-800-390-3507** (TTY **711**), Monday through Friday, 8:00 a.m. to 5:00 p.m. PST. • Be prepared to provide the information listed on the MFA application on the next page.

Important: When applying by mail or fax, or dropping off your application in person, please be sure to fill out the application as much as you can. Any missing information may delay the application process.

What to expect after you apply

After we review your completed application, we'll let you know one of the following outcomes:

- Your application was approved and you'll get a financial award.
- To complete your application, we need additional information or paperwork, which you can send us in the mail or drop off in person; this could include proof of income or copies of your out-of-pocket expenses.
- Your application was denied and why it was denied, in which case you can appeal our decision.

Need help?

If you have any questions or need help with your application, please call **1-800-390-3507** (TTY **711**), Monday through Friday, 8:00 a.m. to 5:00 p.m. PST. You can also talk to a financial counselor at any Kaiser Permanente location.

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Medical Financial Assistance (MFA) Program application

Name: _____ Medical record #: _____

Date of birth: ____/____/____ Contact #: (____) _____ SSN: _____-_____-_____

Address: _____

City: _____ State: _____ ZIP code: _____

Household size: Number of family members (including you) who live in your home. May include a spouse or qualified domestic partner, children, a non-parent caretaker relative, etc. _____

Household income (monthly): Total gross income for all family members in the household. Check ALL income types that apply:

- ☐ Employment Income/Wages
- ☐ Business Income/Rental Property
- ☐ Unemployment Benefits/ Disability Income
- ☐ Alimony/Child Support
- ☐ Pension or Retirement/Annuities
- ☐ Social Security/Supplemental Security Income/Veterans Benefits

$_____

Health care costs: Total out-of-pocket expenses you had over a 12-month period for emergency or medically necessary services provided by Kaiser Permanente or any other health care provider. May include copays, deposits, coinsurance, or deductible payments for eligible medical, pharmacy, or dental services. **$**_____

Please list all members of your household applying for the program.

Name	Date of birth	Relationship	Medical record #
_____	____/____/____	_____	_____
_____	____/____/____	_____	_____
_____	____/____/____	_____	_____
_____	____/____/____	_____	_____
_____	____/____/____	_____	_____

Uninsured? Kaiser Permanente can help. If you do not have health care coverage, we can help you understand your options. Check this box if you would like Kaiser Permanente to contact you to discuss your options. ☐ Yes, contact me

I hereby declare under penalty of perjury that all information set forth above in this application is true and accurate in all respects. I also acknowledge and agree that I am liable to Kaiser Foundation Health Plan and Hospitals for all amounts owing to Kaiser Foundation Health Plan and Hospitals for medical goods and services that are not eligible under the Program (the “Remaining Amounts”).

Signature: _____ Date: _____

Note: Kaiser Foundation Health Plan and Hospitals reserves the right to use information from consumer credit reporting agencies and other third-party information sources to determine eligibility for federal, state, and private medical programs, including the MFA Program.