Kaiser Permanente Subsidy Eligibility Form — 2016

The Kaiser Permanente subsidy is offered as part of Kaiser Permanente’s Bridge Program, to help pay your monthly premiums and most out-of-pocket medical costs under the Kaiser Permanente Georgia Gold 500/20 plan and Pediatric Dental: Delta Dental Insurance Company.

Eligibility for the Kaiser Permanente Bridge Program will be considered for individuals who are uninsured and:

- live in the Kaiser Foundation Health Plan of Georgia, Inc. service area
- are between the ages of 18 and 64 and are actively enrolled students or participants in a training program with a participating Kaiser Permanente community partner
- live in a household with incomes below 100% of the Federal Poverty Level
- do not have access to any other public or private health coverage including, but not limited to, Medicaid, Medicare, job-based coverage, or coverage under Healthcare.gov
- have not previously been enrolled in the Kaiser Permanente Bridge Program

Even if you have an affordability exemption from the federal government you must still meet all the eligibility criteria listed above to be approved for Kaiser Permanente’s Bridge Program. U.S. citizenship is not an eligibility requirement.

Frequently Asked Questions

1. How do I apply for Kaiser Permanente’s Bridge Program?

   You must complete 2 separate documents:
   - For health coverage – complete the Kaiser Permanente for Individuals and Families application.
   - For the Kaiser Permanente subsidy – complete this form for all applicants in your household.

   Please complete the Kaiser Permanente for Individuals and Families application before completing the Kaiser Permanente Subsidy Eligibility form.

   Enrollment in Kaiser Permanente’s Bridge Program is available during the Individuals and Families annual open enrollment and special enrollment periods. In general, the special enrollment period is 60 days after a triggering event such as marriage, birth or adoption of a child, divorce, or loss of job and job-based health coverage. Enrollment into this charitable, subsidized program is limited and subject to availability.

2. What documents do I have to provide to apply for Kaiser Permanente’s subsidy?

   Proof of your most current household gross income:
   - If employer paid – include your last 3 paycheck stubs, W-2 forms or wage and/or tax 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.

   If you receive income from other sources including, but not limited to, Social Security, spousal/child support, unemployment benefits, please include a copy showing proof. If you have received an affordability exemption from the federal government, documentation is required.

Please note: The information including, but not limited to, name, income, and address, that you provide on this form will be used by Kaiser Permanente to determine your eligibility for Kaiser Permanente’s subsidy and your eligibility for other health care or social service programs, or for any other purpose required by law.

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 any other purpose required by law.
3. **How long does it take to determine eligibility for Kaiser Permanente’s Bridge Program?**
   Completed forms can take up to 30 business days to process as long as all required documentation is included. Completion of this form does not guarantee enrollment in Kaiser Permanente’s Bridge Program.

4. **What if I’m not accepted for the Bridge Program?**
   If you are not accepted and still want to purchase a Kaiser Permanente Individual and Family plan on your own, please call our National Direct Sales Center at 1-866-329-3468 or visit www.buykp.org.

5. **How much will I pay each month for the Kaiser Permanente Bridge Program?**
   There is no monthly payment required. Kaiser Permanente will subsidize the full monthly premium.

6. **What happens when I no longer meet the eligibility requirements for the Bridge Program?**
   When you no longer meet our eligibility requirements, you will be dis-enrolled from Kaiser Permanente's Bridge Program, which includes the Kaiser Permanente subsidy and medical financial assistance, and you will be responsible for the Kaiser Permanente Georgia Gold 500/20 plan and Pediatric Dental: Delta Dental Insurance Company monthly premium and any out-of-pocket expenses you incur.

**Instructions to complete this form:**
- Use only black or blue ink to complete this form.
- Check that you have:
  - answered all questions completely
  - provided proof of current income
  - signed both this form and the Kaiser Permanente for Individuals and Families application
  - provided proof of guardianship (if applicable)
- Please make a copy of your completed forms for your records.
- Mail the completed Kaiser Permanente for Individuals and Families application, Kaiser Permanente Subsidy Eligibility form and proof of current income to:
  - Charitable Health Coverage Operations
  - Kaiser Permanente
  - PO Box 24670
  - Oakland, CA 94623-9920
  - Fax: 877-705-6970

We are here to help you. If you have any questions about completing this form, please call us toll free at 1-888-387-0180, or visit kpgabridge.org.
### Step 1. Applicant and Dependent Information

Name of the **Primary Applicant** (e.g., parent or legal guardian for applicants under 18), who will be covered by the health plan. The primary applicant must reside in our service area.

<table>
<thead>
<tr>
<th>Name of the Applicant</th>
<th>Middle Initial</th>
<th>Last Name</th>
<th>Date of Birth</th>
</tr>
</thead>
</table>

Street Address (no P.O. boxes please)

<table>
<thead>
<tr>
<th>Street Address</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
<th>Phone Number</th>
</tr>
</thead>
</table>

Please answer the following questions about the **Primary Applicant** (check Yes or No below).

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is the Primary Applicant who will be covered by the health plan...</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A U.S. citizen?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A legal permanent resident? If Yes, how many years has the primary applicant been a legal permanent resident?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eligible for health coverage through public programs such as Medicaid and Medicare?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eligible for financial assistance through Health Insurance Marketplace?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Currently receiving or have access to a job-based health plan or another health plan?</td>
<td></td>
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</tbody>
</table>

Please complete the information below for each dependent to be covered by the health plan. Note, all dependents must reside in our service area.

Name of **Dependent 1** (spouse, partner or child) who will be covered by the health plan.

<table>
<thead>
<tr>
<th>Name of Dependent 1</th>
<th>Middle Initial</th>
<th>Last Name</th>
<th>Date of Birth</th>
</tr>
</thead>
</table>

Please answer the following questions about **Dependent 1** (check Yes or No below).

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is Dependent 1, who will be covered by the health plan...</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A U.S. citizen?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A legal permanent resident? If Yes, how many years has the primary applicant been a legal permanent resident?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eligible for health coverage through public programs such as Medicaid and Medicare?</td>
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<td></td>
</tr>
<tr>
<td>Eligible for financial assistance through Health Insurance Marketplace?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Currently receiving or have access to a job-based health plan or another health plan?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please provide the name of the school or program being attended ____________________________
Name of Dependent 2 (child) who will be covered by the health plan.

First Name ____________ Middle Initial ____________ Last Name ____________ Date of Birth ____________

Please answer the following questions about Dependent 2 (check Yes or No below).

<table>
<thead>
<tr>
<th>Is Dependent 2, who will be covered by the health plan...</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>A U.S. citizen?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A legal permanent resident? If Yes, how many years has the primary applicant been a legal permanent resident?</td>
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<td></td>
</tr>
<tr>
<td>Eligible for health coverage through public programs such as Medicaid and Medicare?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eligible for financial assistance through Health Insurance Marketplace?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Currently receiving or have access to a job-based health plan or another health plan?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please provide the name of the school or program being attended ____________________________

Name of Dependent 3 (child) who will be covered by the health plan.

First Name ____________ Middle Initial ____________ Last Name ____________ Date of Birth ____________

Please answer the following questions about Dependent 3 (check Yes or No below).

<table>
<thead>
<tr>
<th>Is Dependent 3, who will be covered by the health plan...</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>A U.S. citizen?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A legal permanent resident? If Yes, how many years has the primary applicant been a legal permanent resident?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eligible for health coverage through public programs such as Medicaid and Medicare?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eligible for financial assistance through Health Insurance Marketplace?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Currently receiving or have access to a job-based health plan or another health plan?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please provide the name of the school or program being attended ____________________________

If you are applying for more than four people to receive the subsidy, please photocopy this page and provide the same information requested above for each additional dependent.

**Step 2. Family Size, Employment, Income and Deductions**

1. What is the total number of people that you claim as dependents, including yourself? (e.g., parents/guardians, spouse/domestic partner, and children) _________
   (For example, a single parent/guardian who lives with one child is considered a family of two)

2. **Primary Applicant** (who will be covered by the health plan)
   Name ____________________________ Health Record Number: ____________ (If applicable)
   Employment Status:
   □ Full-time    □ Part-time    □ Unemployed    □ Self-employed    □ Retired    □ Disabled    □ Student
   Pay Frequency:
   □ Daily; Pay amount ______    □ Weekly; Pay amount ______    □ Monthly; Pay amount ______
   □ Bi-weekly; Pay amount ______    □ Semi-monthly; Pay amount ______    □ Other _______; Pay amount ______
   Pay source:
   □ Wages    □ Self-employment    □ Pension    □ Student    □ Other ____________________________
Parent or legal guardian for applicants under 18, if different from the primary applicant 
(write N/A if not applicable)

<table>
<thead>
<tr>
<th>Name</th>
<th>Health Record Number: (If applicable)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Employment Status:
- Full-time
- Part-time
- Unemployed
- Self-employed
- Retired
- Disabled
- Student

Pay Frequency:
- Daily; Pay amount ______
- Weekly; Pay amount ______
- Monthly; Pay amount ______
- Bi-weekly; Pay amount ______
- Semi-monthly; Pay amount ______
- Other _______; Pay amount ______

Pay source:
- Wages
- Self-employment
- Pension
- Student
- Other

Spouse or Domestic Partner

<table>
<thead>
<tr>
<th>Name</th>
<th>Health Record Number: (If applicable)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Employment Status:
- Full-time
- Part-time
- Unemployed
- Self-employed
- Retired
- Disabled
- Student

Pay Frequency:
- Daily; Pay amount ______
- Weekly; Pay amount ______
- Monthly; Pay amount ______
- Bi-weekly; Pay amount ______
- Semi-monthly; Pay amount ______
- Other _______; Pay amount ______

Pay source:
- Wages
- Self-employment
- Pension
- Student
- Other

Dependent 1

<table>
<thead>
<tr>
<th>Name</th>
<th>Health Record Number: (If applicable)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Employment Status:
- Full-time
- Part-time
- Unemployed
- Self-employed
- Retired
- Disabled
- Student

Pay Frequency:
- Daily; Pay amount ______
- Weekly; Pay amount ______
- Monthly; Pay amount ______
- Bi-weekly; Pay amount ______
- Semi-monthly; Pay amount ______
- Other _______; Pay amount ______

Pay source:
- Wages
- Self-employment
- Pension
- Student
- Other

Additional dependents

<table>
<thead>
<tr>
<th>Name</th>
<th>Health Record Number: (If applicable)</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

Employment Status:
- Full-time
- Part-time
- Unemployed
- Self-employed
- Retired
- Disabled
- Student

Pay Frequency:
- Daily; Pay amount ______
- Weekly; Pay amount ______
- Monthly; Pay amount ______
- Bi-weekly; Pay amount ______
- Semi-monthly; Pay amount ______
- Other _______; Pay amount ______

Pay source:
- Wages
- Self-employment
- Pension
- Student
- Other

If you have additional dependents, please photocopy this page and provide the same information requested above for each additional dependent.
3. Please list your total household gross income for the last calendar month in the chart below. Do not leave any spaces blank. If an item does not apply, write “N/A” (not applicable). Attach copies of the most current proof of income for the items included below (examples: pay stubs; award letters for Social Security, spousal/child support, or unemployment benefits; a 1040 from previous tax year; W-2 from current employer; letter from employer; or a bank statement).

<table>
<thead>
<tr>
<th>Total Household Gross Income (for the last calendar month)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gross income from wages, tips $</td>
</tr>
<tr>
<td>Social Security benefits $</td>
</tr>
<tr>
<td>Support or gifts from family/friends $</td>
</tr>
<tr>
<td>Spousal/child support $</td>
</tr>
<tr>
<td>Unemployment benefits $</td>
</tr>
<tr>
<td>Workers compensation $</td>
</tr>
<tr>
<td>Other income $</td>
</tr>
</tbody>
</table>

4. Does anyone in your household have any income deductions?  
☐ Yes  ☐ No.  
These deductions might help you qualify for the Kaiser Permanente subsidy. Examples of income deductions include alimony, child support, and child care.

<table>
<thead>
<tr>
<th>Who receives the deduction?</th>
<th>Type of Deduction</th>
<th>Amount Paid</th>
<th>Frequency of Payment</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

5. Self-employment — If any member of your household is self-employed, please submit a copy of page 1 (the adjusted gross income page) of last year’s federal income tax return, or a profit and loss form, for each business.

**Step 3. Certification**

By signing this form, you certify the information on this form is correct and accurate. If you provide any 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 Bridge Program is not guaranteed as it is based on eligibility and availability.

Print Name (primary applicant or financially responsible party, parent or legal guardian for applicants under 18)

Signature

Date
Your Representative

You can choose a community partner/agency representative, relative, or friend to act for you on matters related to this form, including getting information about this form and signing the form for you. If you ever need to change your representative, contact us.

Name of authorized representative (please be sure to provide the name of the same authorized representative you listed on the Kaiser Permanente for Individuals and Families Application):

First Name     Middle Initial     Last Name

Organization Name     Kaiser Permanente entity enrollment number (if applicable)

Street Address (no P.O. boxes please)

City     State     Zip     Phone Number

Signature to authorize the representative (listed above) to sign the Kaiser Permanente Subsidy Eligibility form, get official information about this form, and act for you on all future matters regarding this form.

Print Name (primary applicant or financially responsible party, parent or legal guardian for applicants under 18)

Signature

Date