Kaiser Permanente

Medical Financial Assistance Program and Discount Payment Program

KAISER PERMANENTE®

The Kaiser Permanente Medical Financial Assistance Program (MFAP) and Discount Payment Program

If you need help paying for medical services, you may be eligible for the Kaiser Permanente Medical Financial Assistance 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.

The MFAP may help pay 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 to your application to the MFAP, you must apply for any private or public 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 to those sources or the approval or denial of your application. 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 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.

  — You're enrolled in Medi-Cal with a Share of Cost.

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 services or venture services,

If your family size is	Your annual income at 200% 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	$21,660	$37,905	$43,320
2	$29,140	$50,995	$58,280
3	$36,620	$64,085	$73,240
4	$44,100	$77,175	$88,200
For each additional person add:	$ 7,480	$13,090	$14,960

Note: These figures are in effect until March 31, 2010. FPG levels may change after that date.

Submitting your application

Please detach and send your completed application with any required supporting documentation to:

Medical Financial Assistance Program and Discount Payment Program

in Northern California:
P.O. Box 30006
Walnut Creek
CA 94598
FAX: **1-800-687-9901**

in Southern California:
P.O. Box 7086
Pasadena
CA 91109-7086
FAX: **1-866-497-0005**

If you have any questions or need help completing your application, call us toll free at **1-866-399-7696,** weekdays from 8 a.m. to 5 p.m. The Central Unit is closed from 11:30 a.m. to 12:30 p.m.

transportation, over-the-counter drugs, brand medications when generics exist, and lifestyle medications (fertility, cosmetic, lifestyle, 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; **or**
- Copies of other documents to verify income, such as letters from disability, Social Security, or unemployment agencies; **or**
- If you have no income, a letter of support that explains your means of living; **and**
- If you're applying under special circumstances, any additional expense information that may be requested of you.

Be sure to send only photocopies, as originals will not be returned. You'll have an opportunity to appeal the decision if your application is denied.

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

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Application

APPLICANT(S)

Patient name:* _____
Medical record number:* _____
Address:* _____
City, State, ZIP:* _____
Phone number:* (_____) _____
Social Security number: _____ – _____ – _____
Date of birth:* _____
Marital status: ☐ Married ☐ Divorced
☐ Widow(er) ☐ Single ☐ Domestic partner
☐ Check here if you want your spouse to be considered for financial assistance.
Spouse's name: _____
Spouse's Social Security number: ___ – ___ – ____
Spouse's date of birth: _____
Medical record number: _____
Number of family members in household (including yourself)?: _____

Please list all the household dependents you support. (Check the box next to each dependent's name below if he or she is applying for the MFAP or Discount Payment Program.)

☐ Name: _____
Age: _____ Relation: _____
Medical record number: _____

☐ Name: _____
Age: _____ Relation: _____
Medical record number: _____

☐ Name: _____
Age: _____ Relation: _____
Medical record number: _____

You are a Kaiser Permanente (check box that applies):
☐ Member ☐ Nonmember

Date(s) of service(s) for which you're applying for your MFAP award: From: _____ To: _____

Medical facility where you receive services:*

_____

What service(s) are you applying for?
☐ Hospital ☐ Medical office visit ☐ Pharmacy
☐ Special circumstances / other (explain):

_____

Employment status:*
Currently employed? ☐ Yes ☐ No
Is spouse employed? ☐ Yes ☐ No

*Required field.

Section A: CURRENT MONTHLY INCOME *(All income from household must be reported.)*

If household income is zero, please initial here _____ and give a brief explanation of your financial situation:

_____

_____

	PATIENT	SPOUSE
Gross monthly salary / wages (before taxes)	$_____	$_____
Cash income (not including gifts)	$_____	$_____
Gross Social Security / SSI or SDI (before taxes)	$_____	$_____
Other income: ☐ Unemployment benefits	$_____	$_____
☐ Pension income	$_____	$_____
☐ Monthly rental income	$_____	$_____
☐ Alimony or child support	$_____	$_____
☐ Other sources (describe) _____	$_____	$_____
Total monthly income:	$_____	$_____

Section B: MEDICAL EXPENSES

(If your household income exceeds 350 percent of the Federal Poverty Guidelines (FPG) or if you're applying for special circumstances, you must complete this section. Copies must be included.)

Hospital and medical office expenses

Name of Medical Center or Medical Office: _____

Out-of-pocket expenses due or paid in the past 12 months:

☐ Hospital or office visits: $_____

☐ Medications: $_____

☐ Other expenses (please describe): $_____

_____

☐ Medi-Cal Share of Cost, if applicable: $_____

☐ If you're a deductible HMO member, provide yearly deductible: $_____

Section C: MEDI-CAL SCREENING *(If you don't currently have Medi-Cal, you must complete this section.)*

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

1) Have you applied for Medi-Cal? ☐ Yes ☐ No

If you answer YES to any of the questions below, contact your local County Social Security Office

2) Are you blind or disabled (12 months or more)? ☐ Yes ☐ No

3) Are you under 21 or over 65 years of age? ☐ Yes ☐ No

4) Are you pregnant or have you been pregnant in the last 3 months? ☐ Yes ☐ No

5) Have you been diagnosed with breast or cervical cancer? ☐ Yes ☐ No

6) Are you living in a skilled nursing facility or an intermediate care home? ☐ Yes ☐ No

7) Do you have children under the age of 21 (including unborn or adopted children) in the home? ☐ Yes ☐ No

8) Do you receive financial assistance from CalWORKs, Supplemental Security Income, Entrant or Refugee Cash Assistance (ECA/RCA), Foster Care or Adoption Assistance Program, or Child Protective Services? ☐ Yes ☐ No

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Section D: LIMITED INCOME SUBSIDY (LIS) SCREENING *(All applicants **must** complete this section.)*

If you're a Medicare 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 beneficiaries who need help paying for their monthly premium, yearly deductible, prescription coinsurance and copayments, and related medical expenses.

1) Do you have Medicare **and** Supplemental Security Income or Medi-Cal? ☐ Yes ☐ No
   If YES, stop: You may automatically be enrolled under the LIS program.
   Please contact Medicare at **1-800-633-4227.**

If you answer YES to 2 and 3 you **must** apply for Medicare LIS. To apply, contact LIS at **1-800-772-1213** or contact your local Social Security office.

2) 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

3) Do your resources or assets (e.g., savings accounts or investments) total less than $12,510 if you're single or $25,010 if you're married and living with your spouse? ☐ Yes ☐ No

If you've already applied for Medicare LIS and have a recent denial or pending letter, please submit a copy with your MFAP 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 (check all that apply):

- ☐ I don't receive a formal pay stub from my employer.
- ☐ I receive no income (excluding monetary gifts from friends or relatives).
- ☐ I wasn't required to file a 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 consent to and 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 consent to and acknowledge and agree that we are each jointly and severally liable to KFHP 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 _____

If you have other health care coverage in addition to the coverage described in your *Evidence of Coverage (EOC)*, you'll usually be eligible to establish or contribute to a health savings account (HSA), unless both forms of coverage qualify as high deductible health plans. Consult with your financial or tax advisor for tax advice or for help in determining whether you're eligible for an HSA.

Applying for the Discount Payment Program

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

- You must be uninsured or underinsured and ineligible for all other public programs (Medi-Cal, Healthy Families, etc.).
- Your household income must be at or below 400 percent of the Federal Poverty Guidelines (FPG).
- If you're insured, you must have high medical expenses and have out-of-pocket costs, incurred or paid by you during the last 12 months, that exceed 10 percent of your household income.
- You must be receiving medically necessary care and all services must be billed by a Kaiser Permanente hospital or medical provider.

Documentation required:

- A copy of a current pay stub, as above; **or**
- A copy of your most recent federal tax return, with electronic submission verification or your signature; **or**
- Copies of other documents to verify income, such as letters from disability, Social Security, or unemployment agencies; **and**
- If you have no income, a letter of support that explains your means of living.
- To document high medical costs, copies of patient or family out-of-pocket expenses during the previous 12 months.

Be sure to send only photocopies, as originals will not be returned. You'll have an opportunity to appeal the decision if your application is denied.

Use the chart on the previous page to determine if your household income is at or below 400 percent of the Federal Poverty Guidelines (FPG).

Help in your language

Interpreter services

Interpreters are available 24 hours a day, seven days a week, at no cost to you. We can also provide you, your family, and 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 intérpretes disponibles las 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. Para más información, llame a nuestro Centro de Llamadas de Servicios a los Miembros al **1-800-788-0616** ó **1-800-777-1370** (TTY) los días de semana de 7 a.m. a 7 p.m., y los fines de semana de 7 a.m. a 3 p.m.

口譯服務

口譯員每天 24 小時、每週 7 天提供服務，您完全不需要支付任何費用。我們也針對您、您家人和朋友，提供使用我們設施和服務時所需的任何特殊協助。另外，您也能夠取得以您使用的語言編寫的資料。如需詳細資訊，請聯絡會員服務中心，電話是 1-800-757-7585，星期一至星期五服務時間為早上 7 點至晚上 7 點，週末服務時間為早上 7 點至下午 3 點。失聰、有聽力或語言障礙的會員可撥打 TTY 服務專線，電話是 1-800-777-1370。

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