



KAISER PERMANENTE

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## Medical Financial Assistance Program 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 (MFAP) 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 discount from Medicare, you can apply for a pharmacy waiver using this application.

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## Applying for the Medical Financial Assistance Program

You must meet the following criteria to be eligible for the Medical Financial Assistance Program (MFAP):

**Other Payer Sources**—Concurrent to 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 **gross** 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. Note: The MFAP may not be able to assist with associated charges for services rendered by a non-Kaiser Permanente provider, even if they are referred by a Kaiser Permanente 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 your household income is zero, a written letter that explains your means of living is required with your application; **and**
- Any other documentation that may be requested.

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.

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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.
- 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" section of this brochure.

**Kaiser Permanente reserves the right to amend or retract awards.**

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## Submit your application to:

### Medical Financial Assistance Program and Discount Payment Program

PO Box 7086

Pasadena, CA 91109-7086

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

Fax: **1-866-497-0005**

Hours: Weekdays from 8 a.m. to 5 p.m.

Note: The general processing time is approximately 30 business days.

Obtain future applications at **[kp.org/mfa](http://kp.org/mfa)**.





## 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** 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。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's name:\* \_\_\_\_\_

Medical record number:\* \_\_\_\_\_

Address:\* \_\_\_\_\_

City, State, ZIP:\* \_\_\_\_\_

Social Security number: \_\_\_\_\_

Phone number:\* ☐ Cell ☐ Home ☐ Work \_\_\_\_\_

Email address: \_\_\_\_\_

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:

Name: \_\_\_\_\_

Medical record number: \_\_\_\_\_

Social Security number: \_\_\_\_\_ Date of birth: \_\_\_\_\_

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:\* \_\_\_\_\_

What are you requesting financial assistance for?

☐ Pharmacy services **only**

☐ Outstanding balance for services provided within the last six months by a Kaiser Permanente provider at a Kaiser Permanente facility

☐ Future services provided by a Kaiser Permanente provider at a Kaiser Permanente facility

Employment status:\*

Currently employed? ☐ Yes ☐ No Spouse/domestic partner employed? ☐ Yes ☐ No

\*Required field

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

If your household income is zero, a written letter that explains your means of living is required with your application.

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

Who is the primary wage earner? (check one) ☐ Patient ☐ Spouse/Other

**Gross** monthly salary/wages (before taxes) \$ \_\_\_\_\_ \$ \_\_\_\_\_

Cash income (not including gifts) \$ \_\_\_\_\_ \$ \_\_\_\_\_

**Gross** Social Security income \$ \_\_\_\_\_ \$ \_\_\_\_\_

Other income: ☐ Unemployment benefits \$ \_\_\_\_\_ \$ \_\_\_\_\_

☐ State disability income \$ \_\_\_\_\_ \$ \_\_\_\_\_

☐ Alimony or child support \$ \_\_\_\_\_ \$ \_\_\_\_\_

☐ Pension income \$ \_\_\_\_\_ \$ \_\_\_\_\_

☐ Rental property income\* \$ \_\_\_\_\_ \$ \_\_\_\_\_

☐ Self-employment income\* \$ \_\_\_\_\_ \$ \_\_\_\_\_

☐ Other sources (describe) \_\_\_\_\_

\$ \_\_\_\_\_ \$ \_\_\_\_\_

**Total monthly income:** \$ \_\_\_\_\_ \$ \_\_\_\_\_

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

**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 of receipts and/or itemized invoices are required.)

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

☐ Hospital or office visits: \$ \_\_\_\_\_

☐ Prescribed medications: \$ \_\_\_\_\_

☐ Other expenses (please describe): \$ \_\_\_\_\_

### SECTION C: MEDI-CAL SCREENING *(All applicants are **REQUIRED** to complete this section of the application.)*

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

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

- Are you younger than 21 or older than 65? ..... ☐ Yes ☐ No
- Are you currently enrolled in Supplemental Security Income (SSI)/State Supplemental Payment (SSP) or Security Disability Insurance? ..... ☐ Yes ☐ No
- Are you enrolled in CalWorks (AFDC), Entrant or Refugee Cash Assistance (ECA/RCA), Foster Care or Adoption Assistance Programs, or In-home Support Services (IHSS)? ..... ☐ Yes ☐ No
- Are you legally blind? ..... ☐ Yes ☐ No
- Are you permanently disabled? ..... ☐ Yes ☐ No
- Are you pregnant or have you been pregnant in the last three months? ..... ☐ Yes ☐ No
- Have you been diagnosed with breast, cervical, or prostate cancer? ..... ☐ Yes ☐ No
- Are you being transferred to a skilled nursing facility or intermediate home care? ..... ☐ Yes ☐ No
- Do you have children younger than 21 (including unborn or adopted children) in the home? ☐ Yes ☐ No
  - If YES: Is one of the child's parents absent or deceased? ..... ☐ Yes ☐ No
  - Is one of the child's parents permanently disabled? ..... ☐ Yes ☐ No
  - Is the primary wage earner unemployed or working less than 100 hours per month? ..... ☐ Yes ☐ No

### SECTION D: LOW INCOME SUBSIDY 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. The Low Income Subsidy (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 the Medicare LIS and you have a recent denial or pending letter, please submit a copy with your MFAP application.

## SECTION E: MISSING INCOME DOCUMENTATION

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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

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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 is REQUIRED; application cannot be processed without signature.**

Signature of Applicant/Guardian \_\_\_\_\_

Date \_\_\_\_\_

Signature of Spouse/  
Domestic Partner of Applicant/Guardian \_\_\_\_\_

Date \_\_\_\_\_

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