Kaiser Permanente Subsidy Eligibility Form – 2018

The Georgia Bridge Program provides a subsidy to help pay your monthly premiums and most out-of-pocket medical costs under the Kaiser Permanente GA Signature Gold 500/20 plan or the GA Gold 500/20 plan. The Kaiser Permanente subsidy is offered as part of Kaiser Permanente’s Georgia Bridge Program.

Eligibility for the Kaiser Permanente Georgia 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 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
- Applicant and/or applying dependents cannot have been previously enrolled in the Kaiser Permanente Bridge Program
- Do not have access to any other public or private health coverage, including, but not limited to, Medicaid, Medicare, job-based coverage, or coverage through the Georgia Health Insurance Exchange

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 Georgia Bridge Program. U.S. citizenship is not an eligibility requirement.

Enrollment in Kaiser Permanente’s Georgia 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.

How to apply for Kaiser Permanente’s Georgia Bridge Program

Step 1
- 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 you complete the Kaiser Permanente Subsidy Eligibility form.

Step 2
- Include the following documents:
  - Proof of your most current household’s 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.
  - See Section 4 of this form for additional examples of proof of income. If you have received an affordability exemption from the federal government, documentation is required.
  - Proof of your most current household’s income deductions, such as:
    - Student loan interest – include your last student loan statement
    - Alimony paid – include a copy of your check
    - Self-employed – include all receipts

Please note: The information including, but not limited to, name, income, and address, that you provide on this form will be used or disclosed 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.
How to complete and submit the forms for the Georgia Bridge Program:

- Use only black or blue ink to complete the forms.
- Check that you have:
  - Answered all questions completely and provided proof of current income and income deductions
  - Signed both forms
  - Provided proof of guardianship (if applicable)
  - Made a copy for your records
- Mail the completed Kaiser Permanente for Individuals and Families application, Kaiser Permanente Subsidy Eligibility form, and proof of current income and income deductions to:

  California Service Center  
  Attn: CHC  
  P.O. Box 939095  
  San Diego, CA 92193-9095  
  Fax: 858-614-3344

Please note, failure to submit information may delay the processing of your application. We are here to help you. If you have any questions about the forms for the Georgia Bridge Program, please call Member Services toll free at 1-888-865-5813, TTY users call 711, Monday through Friday, 7 a.m. to 7 p.m. Eastern time.

Frequently asked questions:

1. **How long does it take to determine eligibility for Kaiser Permanente’s Georgia 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 Georgia Bridge Program.

2. **What if I’m not accepted into the Georgia Bridge Program?**
   
   If you are not accepted and still want to buy a Kaiser Permanente Individuals and Families plan on your own, please call our Sales Department at **404-364-7001** or visit **buykp.org**.

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

4. **What happens when I no longer meet the eligibility requirements for the Georgia Bridge Program?**
   
   When you no longer meet our eligibility requirements, you will be disenrolled from Kaiser Permanente's Georgia Bridge Program, which includes the Kaiser Permanente subsidy and medical financial assistance. You will remain enrolled in the GA Signature Gold 500/20 plan or the GA Gold 500/20 plan, but you will be responsible for paying the full monthly premium and any out-of-pocket costs unless you ask us to terminate your membership or until you fail to pay the full premium.
### SECTION 1: Parent or legal guardian (if applicable)

Only complete this section if you are a parent or guardian applying for a child under 18.

<table>
<thead>
<tr>
<th>First name</th>
<th>MI</th>
<th>Last name</th>
<th>Date of birth (mm/dd/yyyy)</th>
<th>Mailing address (P.O. box acceptable)</th>
<th>City</th>
<th>State</th>
<th>ZIP code</th>
<th>Phone</th>
</tr>
</thead>
</table>

### SECTION 2: Applicant information

Is the person who will be covered by the health plan and requesting the Georgia Bridge Program subsidy. If applying for a child under 18, the parent or guardian should provide the child’s information below.

<table>
<thead>
<tr>
<th>First name</th>
<th>MI</th>
<th>Last name</th>
<th>Date of birth (mm/dd/yyyy)</th>
<th>Gender:</th>
<th>Kaiser Permanente health record number: (if available)</th>
<th>Mailing address (no P.O. boxes, please)</th>
<th>City</th>
<th>State</th>
<th>ZIP code</th>
<th>Phone</th>
</tr>
</thead>
</table>

Employment status (if applicable): [ ] Full-time [ ] Part-time [ ] Unemployed [ ] Self-employed [ ] Retired [ ] Disabled [ ] Student [ ] Other

Pay amount and frequency: [ ] Daily [ ] Weekly [ ] Monthly [ ] Biweekly [ ] Semi-monthly [ ] Other [ ]

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

Please answer the following questions about the primary applicant. Is the primary applicant who will be covered by the health plan …

- [ ] A U.S. citizen? Yes [ ] No
- [ ] A legal permanent resident? Yes [ ] No
- If Yes, how many years has the primary applicant been a legal permanent resident?
- [ ] Eligible for health coverage through public programs such as Medicaid, PeachCare for Kids? Yes [ ] No
- [ ] Eligible for financial assistance through Georgia Health Insurance Exchange? Yes [ ] No
- If currently receiving or have access to a job-based health plan or another health plan? Yes [ ] No
- If a current or former member of Georgia Bridge Program? Yes [ ] No
### SECTION 3: Family information

**Family member 1**

Please complete this section for each additional family member applying for the health plan, and requesting the Georgia Bridge Program subsidy. If an applicant is under 18, the parent/guardian should complete this section for the applicant.

<table>
<thead>
<tr>
<th>First name</th>
<th>MI</th>
<th>Last name</th>
<th>Date of birth (mm/dd/yyyy)</th>
<th>Gender:</th>
<th>Male</th>
<th>Female</th>
<th>Kaiser Permanente health record number: (if available)</th>
</tr>
</thead>
</table>

Employment status (if applicable):  
- [ ] Full-time  
- [ ] Part-time  
- [ ] Unemployed  
- [ ] Self-employed  
- [ ] Retired  
- [ ] Disabled  
- [ ] Student  
- [ ] Other  

Pay amount and frequency:  
- [ ] Daily  
- [ ] Weekly  
- [ ] Monthly  
- [ ] Biweekly  
- [ ] Semi-monthly  
- [ ] Other  

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

Please answer the following questions about the family member.

Is the family member who will be covered by the health plan …

- [ ] A U.S. citizen?  
- [ ] A legal permanent resident?  
- [ ] Eligible for health coverage through public programs such as **Medicaid, PeachCare for Kids**?  
- [ ] Eligible for financial assistance through **Georgia Health Insurance Exchange**?  
- [ ] Currently receiving or have access to a job-based health plan or another health plan?  
- [ ] A current or former member of Georgia Bridge Program?
SECTION 3: Family information (continued)

Please complete this section for each additional family member applying for the health plan, and requesting the Georgia Bridge Program subsidy. If an applicant is under 18, the parent/guardian should complete this section for the applicant.

**Family member 2**

Please select one of the following:  ☐ Parent/Guardian  ☐ Spouse/Domestic Partner  ☐ Dependent  

<table>
<thead>
<tr>
<th>First name</th>
<th>MI</th>
<th>Last name</th>
<th>Gender:  ☐ Male  ☐ Female</th>
<th>Kaiser Permanente health record number: (if available)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Date of birth (mm/dd/yyyy)  Gender:  ☐ Male  ☐ Female  Kaiser Permanente health record number: (if available)

Employment status (if applicable):  ☐ Full-time  ☐ Part-time  ☐ Unemployed  ☐ Self-employed  ☐ Retired  ☐ Disabled  

☐ Student  ☐ Other ________________

Pay amount and frequency:  ☐ Daily  ☐ Weekly  ☐ Monthly  ☐ Biweekly  ☐ Semi-monthly  ☐ Other ________________

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

Please answer the following questions about the family member.

Is the family member who will be covered by the health plan …

☐ A U.S. citizen?  ☐ Yes  ☐ No

☐ A legal permanent resident?  ☐ Yes  ☐ No

If Yes, how many years has the family member been a legal permanent resident?  

☐ Eligible for health coverage through public programs such as Medicaid, PeachCare for Kids?  ☐ Yes  ☐ No

☐ Eligible for financial assistance through Georgia Health Insurance Exchange?  ☐ Yes  ☐ No

☐ Currently receiving or have access to a job-based health plan or another health plan?  ☐ Yes  ☐ No

☐ A current or former member of Georgia Bridge Program?  ☐ Yes  ☐ No
SECTION 3: Family information (continued)

Family member 3
Please complete this section for each additional family member applying for the health plan, and requesting the Georgia Bridge Program subsidy. If an applicant is under 18, the parent/guardian should complete this section for the applicant.

Please select one of the following: □ Parent/Guardian □ Spouse/Domestic Partner □ Dependent

First name

Last name

Date of birth (mm/dd/yyyy)

Gender: □ Male □ Female

Kaiser Permanente health record number: (if available)

Employment status (if applicable): □ Full-time □ Part-time □ Unemployed □ Self-employed □ Retired □ Disabled □ Student □ Other

Pay amount and frequency: □ Daily □ Weekly □ Monthly □ Biweekly □ Semi-monthly □ Other

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

A U.S. citizen? □ Yes □ No

A legal permanent resident? □ Yes □ No

If Yes, how many years has the family member been a legal permanent resident?

Eligible for health coverage through public programs such as Medicaid, PeachCare for Kids? □ Yes □ No

Eligible for financial assistance through Georgia Health Insurance Exchange? □ Yes □ No

Currently receiving or have access to a job-based health plan or another health plan? □ Yes □ No

A current or former member of Georgia Bridge Program? □ Yes □ No
SECTION 3: Family information (continued)

**Family member 4**

Please complete this section for each additional family member applying for the health plan, and requesting the Georgia Bridge Program subsidy. If an applicant is under 18, the parent/guardian should complete this section for the applicant.

<table>
<thead>
<tr>
<th>First name</th>
<th>MI</th>
<th>Last name</th>
<th>Date of birth (mm/dd/yyyy)</th>
<th>Gender:</th>
<th>Kaiser Permanente health record number: (if available)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Female</td>
<td></td>
</tr>
</tbody>
</table>

**Employment status (if applicable):**
- [ ] Full-time
- [ ] Part-time
- [ ] Unemployed
- [ ] Self-employed
- [ ] Retired
- [ ] Disabled
- [ ] Student
- [ ] Other

**Pay amount and frequency:**
- [ ] Daily
- [ ] Weekly
- [ ] Monthly
- [ ] Biweekly
- [ ] Semi-monthly
- [ ] Other

**Pay source:**
- [ ] Wages
- [ ] Self-employment
- [ ] Pension
- [ ] Student
- [ ] Other

<table>
<thead>
<tr>
<th>Is the family member 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?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If Yes, how many years has the family member been a legal permanent resident?

<table>
<thead>
<tr>
<th>Eligible for health coverage through public programs such as Medicaid, PeachCare for Kids?</th>
<th>[ ] Yes</th>
<th>[ ] No</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Eligible for financial assistance through Georgia Health Insurance Exchange?</th>
<th>[ ] Yes</th>
<th>[ ] No</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Currently receiving or have access to a job-based health plan or another health plan?</th>
<th>[ ] Yes</th>
<th>[ ] No</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>A current or former member of Georgia Bridge Program?</th>
<th>[ ] Yes</th>
<th>[ ] No</th>
</tr>
</thead>
</table>

If you have additional family members, please photocopy this page and provide the same information requested above for each additional member.
SECTION 4: Household income

What is the total number of people that contribute to your total household gross income, including yourself?_______.

Please list your **total** household gross income for the last calendar month in the chart below. Be sure to include income from all the people you listed in Sections 1–3, including yourself, and any additional people that contribute to your household income even if they aren’t applying for the Georgia Bridge Program. If an item does not apply, write “N/A” (not applicable).

**Attach copies of the most current proof of income for all the items included below** (examples: pay stubs; award letters for Social Security or unemployment benefits; 1040 from previous tax year; W-2 from current employer; letter from employer; or bank statement).

Does anyone in your household have any income deductions?  □ Yes  □ No

These deductions might help you qualify for the Kaiser Permanente subsidy. Please attach copies of the most current proof of deductions for the items listed below:

<table>
<thead>
<tr>
<th>Total household gross income (for the last calendar month)</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Gross income from wages, tips</td>
<td>$</td>
<td></td>
</tr>
<tr>
<td>Social Security Disability payments (SSDI)</td>
<td>$</td>
<td>Rental income you receive from property you own and lease</td>
</tr>
<tr>
<td>Support or gifts from family/friends</td>
<td>$</td>
<td>Interest income</td>
</tr>
<tr>
<td>Alimony/Spousal support</td>
<td>$</td>
<td>Student financial aid</td>
</tr>
<tr>
<td>Unemployment benefits</td>
<td>$</td>
<td>Other income</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Total income deductions (for the last calendar month)</th>
<th>Who receives the deduction</th>
<th>Amount paid</th>
<th>Frequency of payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student loan interest</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alimony/Spousal support you paid</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self-employed expenses</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other: Please specify</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Self-employment: If any member of your household is self-employed, please submit a copy of Schedule C and page 1 (the adjusted gross income page) of last year’s federal income tax return, or a profit and loss form for each business.
SECTION 5: 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 Georgia Bridge Program is not guaranteed as it is based on eligibility and availability.

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

Date (mm/dd/yyyy)

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

Last name

Organization name (if applicable)

Kaiser Permanente entity enrollment number (if applicable)

Address (no P.O. boxes, please)

City

State

ZIP code

Phone

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.

Date (mm/dd/yyyy)

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