Georgia Bridge Program

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What is the Georgia Bridge Program?

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Bridge Program Overview

The mission of Kaiser Permanente is to provide high-quality, affordable health care services and to improve the health of our members and the communities we serve. As one of the nation's largest nonprofit health plans, we invest into Community Health initiatives which provide valuable services to the vulnerable population of metro Atlanta. We support the community through programs such as as grantmaking, Medicaid, Thriving Schools, Medical Financial Assistance, and the Bridge Program.

The Kaiser Permanente Bridge Program is uniquely designed to provide help to pay for a standard Kaiser Permanente for Individuals and Families (KPIF) Plan to those who are:

- Actively enrolled with a community partner
- Income Eligible
- Uninsured
- Reside in the Kaiser Permanente Service Area

How does it work?

Kaiser Permanente will subsidize the full monthly premium along with medical and pharmacy visits at Kaiser Permanente facilities* **from the time of enrollment until 12/31/2024**. Subscribers may reapply annually at the discretion of Kaiser Permanente if they continue to meet the program eligibility requirements. Coverage includes preventive services, hospitalization, comprehensive pharmacy, and more.

Visit kp.org/gabridge to learn more.

* All covered health care services **must be provided, authorized or prescribed** by the Southeast Permanente Medical Group or an affiliated health care provider. The subsidy will not cover services outside of Kaiser Permanente or elective services.

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Georgia Bridge Program Highlights

This table shows an example of some of your benefits.

Covered service	You pay at our KP Medical Office	You pay at an Affiliated community provider
Primary Care	$0 copay	$20 copay
Specialty Care	$0 copay	$40 copay
Preventative Generic Drugs	$0 copay	$15 copay when filled at a designated community pharmacy
Laboratory Services	$0 copay	30% coinsurance
Radiology Service	$0 copay	$50 copay
Urgent Care	$0 copay	$50 copay
Outpatient Surgery	$0 copay	30% coinsurance after deductible
Mental Health Outpatient	$0 copay	$40 copay
Vision Exam – one exam per year	$0 copay	$20 copay

*This is a summary of some benefits and their copays and coinsurance. For specific information about your covered health plan benefits, limitations, and exclusions, including those not listed in this summary, please see your *Evidence of Coverage.*

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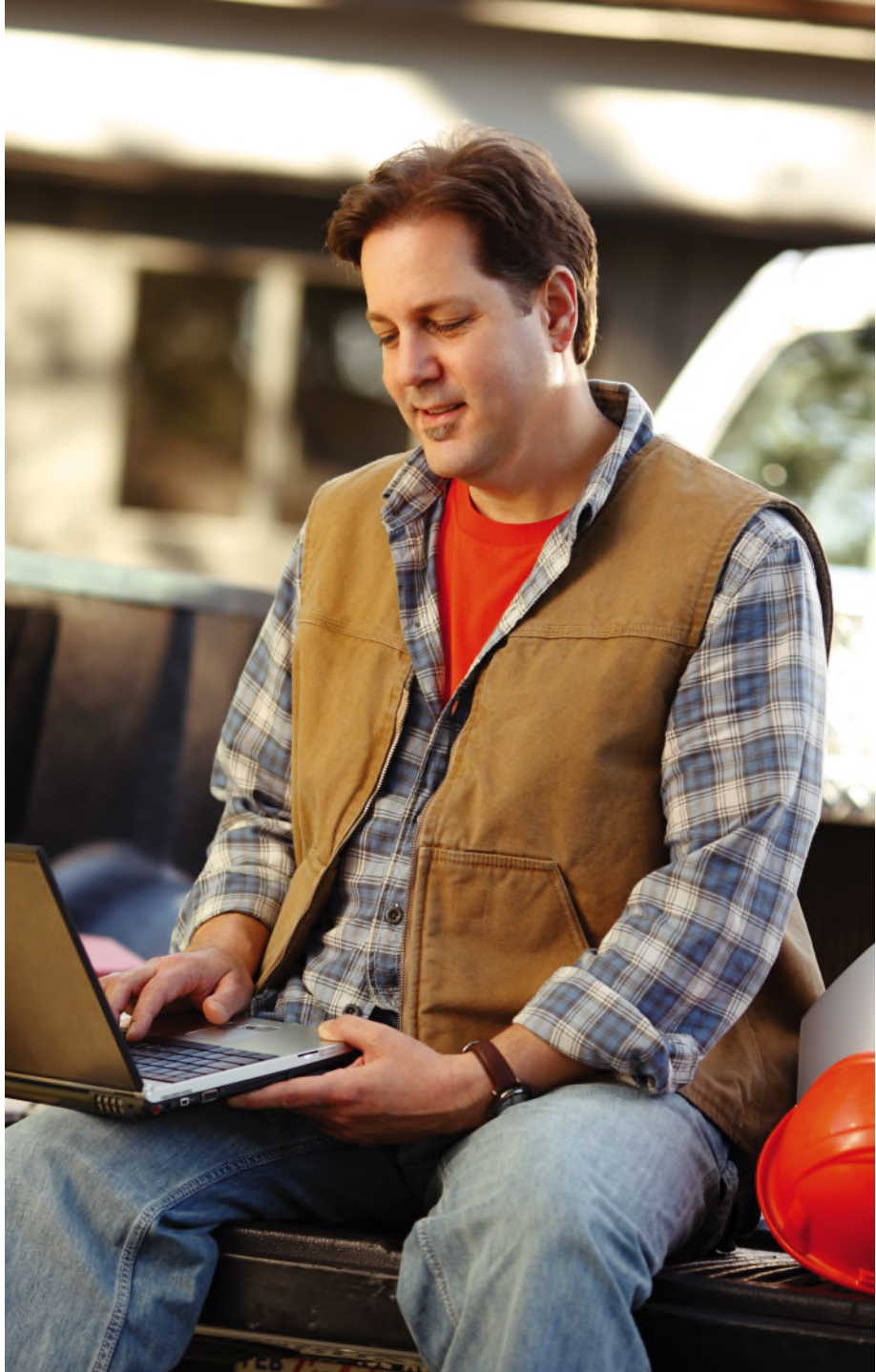
Eligibility Requirements

The applicant must meet the following eligibility requirement in order to receive subsidized health care coverage under the Bridge Program:

- The applicant must be actively enrolled with a participating community partner.
- All applicants, and applying dependents, must live in Kaiser Permanente's metro Atlanta 20 county service area[1].
- The annual combined household income for the applicant must be less than the current income guidelines of 100% FPL for enrollment.
- The primary applicant and all applying dependents cannot be eligible for other public or private health coverage such as, but not limited to, Medicaid, PeachCare for Kids®, Medicare, an affordable job-based health plan, or financial help through the health benefit exchange.
- All child dependents must be younger than 26.

1. Bartow, Butts, Cherokee, Clayton, Cobb, Coweta, DeKalb, Douglas, Fayette, Forsyth, Fulton, Gwinnett, Henry, Lamar, Newton, Paulding, Pike, Rockdale, Spalding, and Walton counties.



Participating Community Partners

Workforce Development Agencies	Colleges and Universities	Service Organizations
Response to growing workforce shortage	Strategically targets healthcare of professional students	Intended to reach individuals/families facing short-term issues
Goodwill of North Georgia	Chattahoochee Technical College	Atlanta Children's Shelter
Gwinnett Technical College WIOA	Clayton State University, College of Health	Atlanta Community Food Bank
STRIVE Atlanta	Georgia State University Perimeter College, School of Nursing	Center for Black Women's Wellness
WorkSource Cobb	Georgia State University, College of Nursing and Health Professions	East Lake Healthy Connections
WorkSource DeKalb		Georgia Organics
WorkSource Fulton		First African Community Development Corporation
WorkSource Metro Atlanta: • Cherokee Career Resource Center • Clayton Career Resource Center • Douglas Career Resource Center • Gwinnett Career Resource Center • Rockdale Career Resource Center		Multi-Agency Alliance for Children, Inc. (MAAC)
Year Up Greater Atlanta		New Life Community Alliance
		Nicholas House
		North Fulton Community Charities
		Zion Hill Community Development Corporation

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2023 Income Guidelines

Family Size	Monthly Gross Income	Annual Gross Income
1	$1,215	$14,580
2	$1,643	$19,720
3	$2,072	$24,860
4	$2,500	$30,000
5	$2,928	$35,140
6	$3,357	$40,280
7	$3,785	$45,420
8	$4,213	$50,560

For families/households with more than 8 people, add $5,140 for each additional person per year.

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Reapplication Opportunity

How do I reapply for an additional 12 months of coverage through the Bridge Program in 2025?

- If we determine we can provide an additional 12 months of subsidized coverage, Kaiser Permanente will ***mail*** the Reapplication Kit to the current address we have on file in late July/early August 2024.
- You can complete the reapplication form by hand or request a fillable PDF from your community partner. The Reapplication Period runs from August 1, 2024 – October 1, 2024
- It is extremely important to keep your address current with us to ensure you are receiving the latest communications. If you have a change in your address, please contact our Member Services Contact Center at 1-888-865-5813.
- You must continue to meet ALL eligibility criteria and submit the following documents:

    1. Completed Reapplication Form
    2. Most up-to-date income information
    3. The ***Community Partner Verification Letter*** provided by the partner you are affiliated with

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Why choose Kaiser Permanente?

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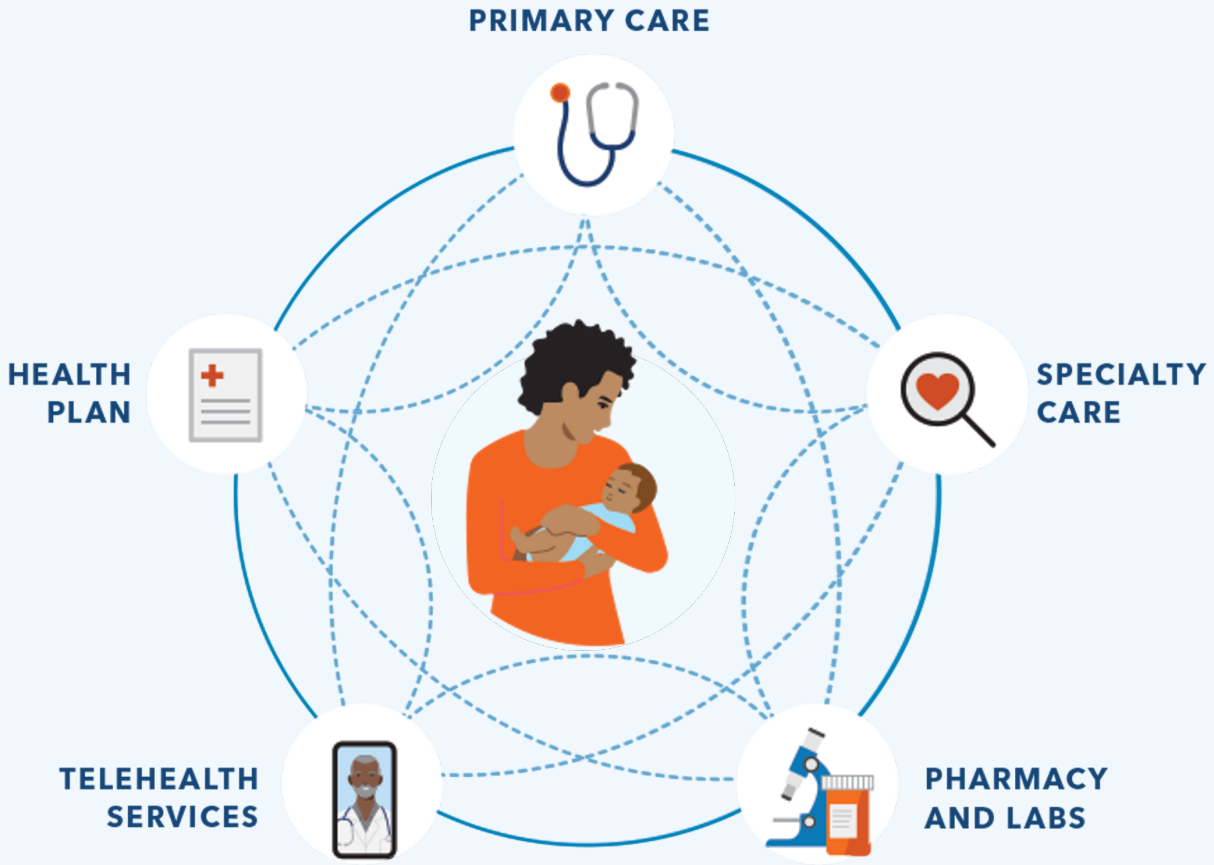
Connected care that’s built to make your life easier



We combine care and coverage, which means our doctors, medical facilities, and health plan work together to deliver high-quality care that fits your needs.

It’s easier to see top specialists and get the latest treatments.

It’s the right care, when you need it.

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Care that's **personalized**

Your doctor is your best health advocate. They learn what matters most to you and work with you to build a care plan that fits your health needs, personal preferences, and values.

Care teams that feel reflective of who you are

- Access many clinicians who speak more than one language
- Utilize interpretive services for more than 150 languages
- Browse doctor profiles and change your personal doctor anytime

Learn more about our doctors at kp.org/doctors.

Connected by your electronic health record

Your health history lives on your electronic health record.

It helps connect your care through each visit, including with specialists.

Your records are available to you and your care team 24/7.

It helps ensure you don't miss checkups and tests.

KAISER PERMANENTE®

Care that's **convenient**

We make it easy to get high-quality care when and where you want it. No matter how you connect, you'll always talk with a medical professional who can see your health history and pick up where you left off.

Learn more at **kp.org/mobile**

Your health at your fingertips

- Get 24/7 care by phone or video*
- Email your care team
- Schedule appointments
- View lab results and doctor's notes
- Refill prescriptions
- Check in for appointments
- Pay bills and view statements

FAST COMPANY | THE WEBBY AWARDS

Our mobile app won Fast Company's 2022 Design Company of the Year and the 2022 People's Voice Webby award for Health and Fitness Apps.

*When appropriate and available.

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Convenient prescription refills

Order prescription refills online, on the Kaiser Permanente app, in person, or over the phone.

You can also get refill reminders or alerts when new prescriptions are available to order.

Get your prescriptions:

- At any Kaiser Permanente pharmacy, including same-day pickup
- Delivered to your door with same-day or next-day delivery[1,2]

1. Not all prescriptions can be mailed, restrictions may apply. Please check with your local pharmacy. **2.** Same-day and next-day prescription delivery services may be available for an additional fee. These services aren't covered under your health plan benefits and may be limited to specific prescription drugs, pharmacies, and areas. Order cutoff times and delivery days may vary by pharmacy location. Kaiser Permanente isn't responsible for delivery delays by mail carriers. Kaiser Permanente may discontinue same-day and next-day prescription delivery services at any time without notice and other restrictions may apply. Medi-Cal and Medicaid beneficiaries should ask their pharmacy for more information about prescription delivery.

Convenient care while traveling

Planning to travel? Have a child going away to college? We can help you stay on top of your health while you're away. We'll work with you before you leave to see if you need to get vaccinated, refill prescriptions, and more.

And you're covered for urgent and emergency care anywhere in the world.

You can always get 24/7 care by email, phone, and video across the nation.*

Visit kp.org/travel to learn more.

***When appropriate and available. If you travel out of state, phone appointments and video visits may not be available in select states due to licensing laws. Laws differ by state.

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Care that's **world class**

No matter your needs — mental health, maternity, cancer care, heart health, and beyond — you'll have access to expert doctors, advanced technology, and the latest evidence-based care.

We're a national leader in screening rates and research, and we're among the top-rated health plans in every state we serve.[1,2,3]

Kaiser Permanente members are:

33%
more likely to survive heart disease[4]

52%
more likely to survive colorectal cancer[5]

20%
less likely to experience premature death due to cancer[6]

1. Kaiser Permanente 2022 HEDIS® scores. **2.** 2021 Annual Report, Kaiser Permanente, about.kaiserpermanente.org/who-we-are/annual-reports/2021-annual-report. **3.** NCQA's Private Health Insurance Plan Ratings 2022–2023, National Committee for Quality Assurance, 2022: Kaiser Foundation Health Plan of Colorado — HMO (rated 4 out of 5); Kaiser Foundation Health Plan of Georgia, Inc. — HMO (rated 4 out of 5); Kaiser Foundation Health Plan, Inc., of Hawaii — HMO (rated 4 out of 5); Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. — HMO (rated 5 out of 5); Kaiser Foundation Health Plan, Inc., of Northern California — HMO (rated 4.5 out of 5); Kaiser Foundation Health Plan of the Northwest — HMO (rated 4 out of 5); Kaiser Foundation Health Plan, Inc., of Southern California — HMO (rated 4.5 out of 5); Kaiser Foundation Health Plan of Washington — HMO (rated 4 out of 5). **4.** Elizabeth A. McGlynn, PhD, et al., "Measuring Premature Mortality Among Kaiser Permanente Members Compared to the Community," July 20, 2022. **5.** Theodore R. Levin, MD, et al., "Effects of Organized Colorectal Cancer Screening on Cancer Incidence and Mortality in a Large, Community-Based Population," *Gastroenterology*, November 2018. **6.** See note 4.

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Resources for mental health

Kaiser Permanente provides a wide range of support to help you take care of your mental and emotional health.

- Get help with conditions like anxiety, depression, addiction, and autism spectrum disorders.
- Find care with psychiatrists, psychologists, marriage and family therapists, and more.
- Make an appointment for therapy within Kaiser Permanente without a referral.
- Use online self-care resources at any time to help you relieve stress, improve sleep, practice mindfulness, and more.

Learn more at **kp.org/mentalhealth**.

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Resources for self-care

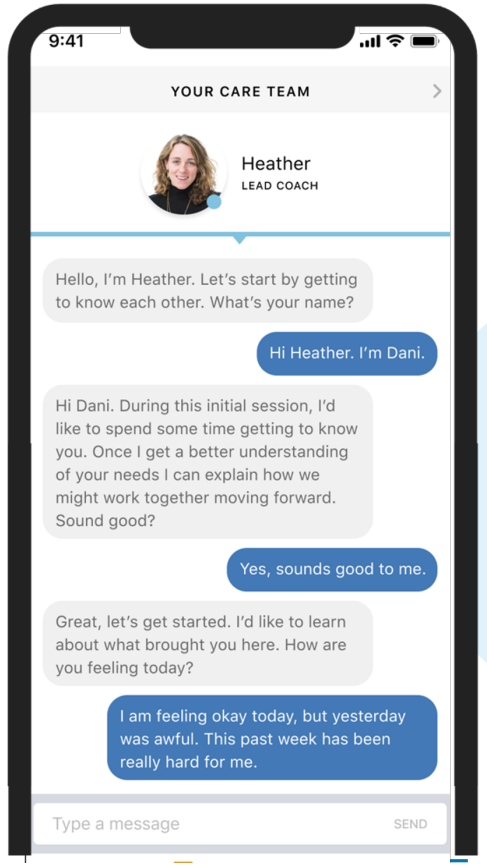
You have access to apps to help reduce stress, improve sleep, and manage overall mental wellness.[1,2]

Visit kp.org/selfcareapps to learn more.

Calm
The number one app for sleep and meditation

Ginger
Text one-on-one with an emotional support coach anytime, anywhere.[3]

myStrength
Build a personalized plan to strengthen your emotional health.



47%

of users say Ginger helps with anxiety[4]

1. The apps and services described above are not covered under your health plan benefits, are not a Medicare-covered benefit, and are not subject to the terms set forth in your *Evidence of Coverage* or other plan documents. The apps and services may be discontinued at any time. **2.** Calm and myStrength can be used by members 13 and over. The Ginger app and services are not available to any members under 18 years old. **3.** Eligible Kaiser Permanente members can text with a coach using the Ginger app for 90 days per year. After the 90 days, members can continue to access the other services available on the Ginger app for the remainder of the year at no cost. **4.** Knuckle et al., "Association Between Care Utilization and Anxiety Outcomes in an On-Demand Mental Health System: Retrospective Observational Study," *JMIR Formative Research,* 2021.

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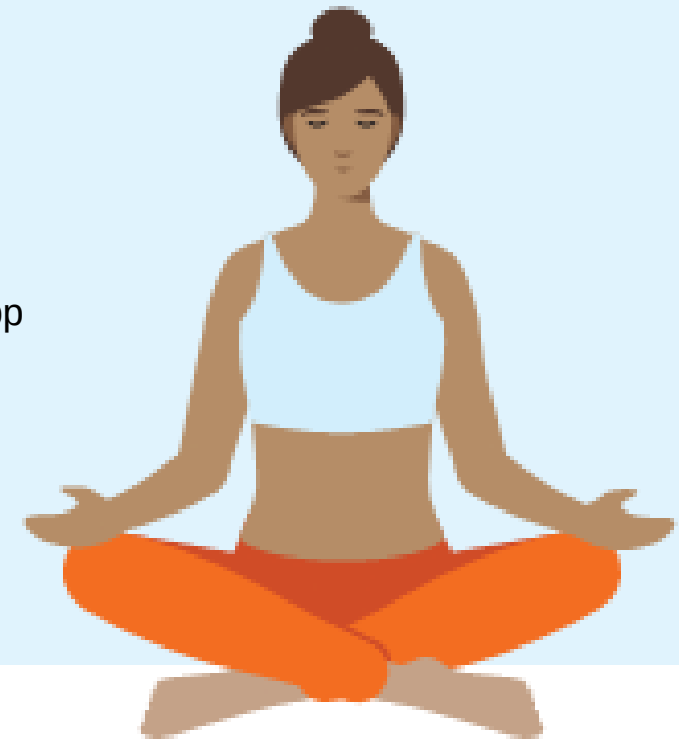
Resources for everyday wellness

Take advantage of classes, services, and programs to help you achieve your health and fitness goals.[1]
Visit **kp.org/health-wellness** to learn more.

- Acupuncture, massage therapy, and chiropractic care
- Reduced rates on gym memberships
- Healthy lifestyle programs and classes[2]
- Wellness Coaching by Phone
- Online fitness with the ClassPass app



1. These services aren't covered under your health plan benefits and aren't subject to the terms set forth in your *Evidence of Coverage* or other plan documents. These services may be discontinued at any time without notice. **2.** Classes vary at each location and some may require a fee.

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Care that's **right for you**

Personalized onboarding

- A welcome call to answer your questions
- A member guide to get you started

3 easy steps to a healthy change

1. Choose your new doctor
2. Transition your care and prescriptions seamlessly
3. Get care on your schedule

Visit kp.org/newmember to learn more.

The Enrollment Process

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2024 Open Enrollment Schedule

The receipt date of your application determines your effective date of coverage:

Application Received Date	Effective Date of Coverage
November 1, 2023 – December 15, 2023	January 1, 2024
December 16, 2023 – January 15, 2024	February 1, 2024

Note: Applicants approved during 2024 Enrollment Period will term 12/31/2024 with the opportunity to reapply for an additional 12 months at the discretion of Kaiser Permanente (refer to slide 9 about the reapplication process)**.**

If you miss the Open Enrollment Period or need to add dependents later, you can apply during the Special Enrollment Period. Special Enrollment is a time outside Open Enrollment during which you have a right to sign up for health coverage because of a qualifying event such as marriage or loss of eligibility under GA Code Section 49-4-1 or 49-5-273. Visit kp.org/chcspecialenrollment or reach out to your community partner to learn more.

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Steps to Enroll

To enroll in the Kaiser Permanente Bridge Program, complete the following steps:

- Complete the Kaiser Permanente for Individuals and Families (KPIF) Application.
- Complete the Community Health Subsidy Eligibility Form.
- Obtain the Community Partner Verification letter from the Community Partner you are affiliated with.
- Submit both applications, the partner verification letter, as well as all other necessary supporting documents to the California Service Center (CSC) via email, fax, or mail*.
- The CSC will process the applications and supporting documents to verify eligibility including income and access to other health insurance programs. If approved, the applicant will receive an acceptance letter with effective date for coverage from the CSC.

*If you plan to fax, be sure to hold onto the fax transmission report. If you plan to mail, certified mail is highly encouraged and ensure you make copies of all your documents in case you need proof of completion in the event it is lost in the mail.

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Application for health coverage

Individual and Family Plans

Who can use this application?	You may use this application to apply for a Kaiser Permanente for Individuals and Families (KPIF) plan. • If you want coverage for your family on the same KPIF plan, please fill out one application for the family. If someone in your family wants a different health plan, they must complete a separate application. • To be eligible for KPIF coverage, you must live in our Georgia service area.
Who should not use this application?	• If you or any dependent you're applying for are entitled to Medicare Part A or are enrolled in Medicare Part B, that applicant is not eligible to apply for new KPIF coverage. Please visit **kp.org/medicare** to learn more about your Medicare plan options or to apply for Medicare coverage. • If you qualify for and want federal financial assistance to help pay for copays, coinsurance, deductibles, or premiums, don't complete this application. You can apply for coverage at **buykp.org/apply**. • To make changes to your existing KPIF account, call **1-888-865-5813** (TTY **711**).
Things to remember	• If you're applying during open enrollment, the date we receive your application may change your effective date – it will usually be January 1 if you apply by December 15. Please send this application back as quickly as you can – or you can apply faster online at **buykp.org/apply**. • If you're applying during a special enrollment period, go to **kp.org/specialenrollment** or call **1-800-494-5314** for instructions. • Please answer all questions, and type or print using ink only. Leave an empty box in between words, and put a hyphen in the box for hyphenated names. • Remember, enrolling in a new plan won't automatically cancel any other coverage you have. To avoid paying for 2 plans or having a gap in coverage, make sure to cancel any other coverage as of the day before your new coverage starts. • **To make sure your application is processed in time and isn't canceled,** please return every page of the application, completed, with all the required signatures, and proof of your qualifying life event (if required). Send these materials by mail to: Kaiser Permanente for Individuals and Families P.O. Box 23127 San Diego, CA 92193-9921 Or send it by secure fax to: **1-855-355-5334** Note: Checks must be mailed and can't be faxed.
Need help?	• For help with completing this application, please call **1-800-494-5314** (TTY **711**). • **We'll provide language assistance at no cost to you.** • If you're working with a broker, please call them for assistance.

All plans are offered and underwritten by Kaiser Foundation Health Plan of Georgia, Inc.
Nine Piedmont Center, 3495 Piedmont Road NE, Atlanta, GA 30305.

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Primary applicant

Jane Smith

STEP 1: Choose your enrollment period

Select one option: ☒ Open enrollment **(skip to Step 2)** ☐ A special enrollment period (continue below)

Choose your qualifying life event. If you had more than one, review your options because effective dates vary by event. **Proof of eligibility is also required within 10 calendar days.** Visit **kp.org/specialenrollment** or call **1-800-494-5314** for more about qualifying life events or if you do not see your qualifying life event below.

- ☐ Loss of minimum essential health coverage (write the last full day you had coverage)*
- ☐ Gaining or becoming a dependent through marriage or domestic partnership
- ☐ Gaining or becoming a dependent through the birth of a child, adoption, or placement for adoption or foster care
  - **Note:** In this case, you also need to choose between 2 effective date options:
  - ☐ The date of birth, adoption, foster care, or placement for adoption or foster care
  - ☐ The first day of the month after the birth or placement of the child with you
- ☐ Child support order or other court order to cover a dependent
  - **Note:** In this case, you also need to choose between 2 effective date options:
  - ☐ The date of the child support order or other court order to cover a dependent
  - ☐ The first day of the month after the court order date
- ☐ Permanent relocation with access to new plans
- ☐ Determination by the health benefit exchange of exceptional circumstances
- ☐ Eligibility to purchase an individual health plan through an individual coverage health reimbursement arrangement (ICHRA) or a qualified small employer health reimbursement arrangement (QSEHRA)
- ☐ Domestic violence or spousal abandonment occurring within the household
- ☐ Discontinuation of employer contribution to COBRA premium

Please write the date of your qualifying life event. ☐☐ / ☐☐ / ☐☐☐☐ (mm/dd/yyyy)

*If your qualifying life event is loss of Kaiser Permanente coverage, we may review membership records to check when and why you lost coverage.

STEP 2: Choose your health plan

Choose one health plan. If any family members are applying for different health plans, please submit a separate application for each plan.

Bronze

- ☐ KP GA Bronze Virtual Complete 5500 Ded/1500 Rx Ded
  KP GA Signature Bronze Virtual Complete 5500/1500 RxDed†
- ☐ KP GA Bronze 6500/40%/HSA
  KP GA Signature Bronze 6500/40%/HSA†
- ☐ KP GA Standard Bronze 7500/50
  KP GA Signature Standard Bronze 7500/50†

Silver

- ☐ KP GA Silver 3400 Ded/500 Rx Ded
  KP GA Signature Silver 3400 Ded/500 Rx Ded†
- ☐ KP GA Silver 4500/35
  KP GA Signature Silver 4500/35†
- ☐ KP GA Standard Silver 5900/40
  KP GA Signature Standard Silver 5900/40†
- ☐ KP GA Silver Virtual Complete 5000
  KP GA Signature Silver Virtual Complete 5000†
- ☐ KP GA Silver Virtual Complete 5500
  KP GA Signature Silver Virtual Complete 5500†

Gold

- ☒ KP GA Gold 500 Ded/500 Rx Ded
  KP GA Signature Gold 500 Ded/500 Rx Ded†
- ☐ KP GA Gold 1500 Ded/500 Rx Ded
  KP GA Signature Gold 1500 Ded/500 Rx Ded†
- ☐ KP GA Gold 2000 Ded/500 Rx Ded
  KP GA Signature Gold 2000 Ded/500 Rx Ded†
- ☐ KP GA Standard Gold 1500/30
  KP GA Signature Standard Gold 1500/30†

For applicants under 30 or with hardship exemptions

Catastrophic plans are available to applicants who will be younger than 30 on the effective date, or who provide a certificate of exemption that shows hardship or lack of affordable coverage. **We won't be able to process your application without the certificate of exemption if you are 30 and older.** To see if you qualify, please go to **healthcare.gov/exemption-form-instructions/** and follow the instructions.

- ☐ KP GA Catastrophic 9450
  KP GA Signature Catastrophic 9450†

†If you live in Clayton, Cobb, DeKalb, Fulton, Gwinnett, or Henry counties, your plan will be in the KP Signature HMO network. Please see the KPIF Enrollment Guide for important information on plans with the KP Signature HMO network.

To request a copy of the *Evidence of Coverage* for a particular plan, please go to **kp.org/plandocuments**, call **1-888-865-5813** (TTY **711**), or contact your broker.

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Primary applicant

Jane Smith

STEP 3: Enter your information

Primary applicant In an individual plan, the primary applicant is the person who will be covered by the health plan. In a family plan, the primary applicant is the family member on the health plan who is authorized to make changes to the account. If this application is only for a child under 18, the child is the primary applicant.

First name: Jane | MI: R | Date of birth (mm/dd/yyyy): 08/07/1980

Last name: Smith

Former medical record number (if any): | State (if any): | Gender: ☐ Male ☒ Female ☐ Undeclared | Social Security number (if any): 987-65-4321

Home address (no P.O. boxes, please): 1234 Main Street

City: Atlanta

State: GA | ZIP code: 30317 | County: Fulton | Phone (mobile phone if available): 404-467-7891

Mailing address ☒ Check if same as home address.

City:

State: | ZIP code:

Preferred language spoken (if not English): | Preferred language read (if not English):

Email address: jane.smith@gmail.com

Applicants 21 and older: Have you used tobacco at least 4 times per week in the past 6 months (except for religious/ceremonial use)? Products include cigarettes, cigars, and chewing/smokeless tobacco. Regular tobacco users may pay different premiums. ☐ Yes ☒ No

Providing your email address is HIGHLY encouraged

If you're 21 and older, you MUST answer this question

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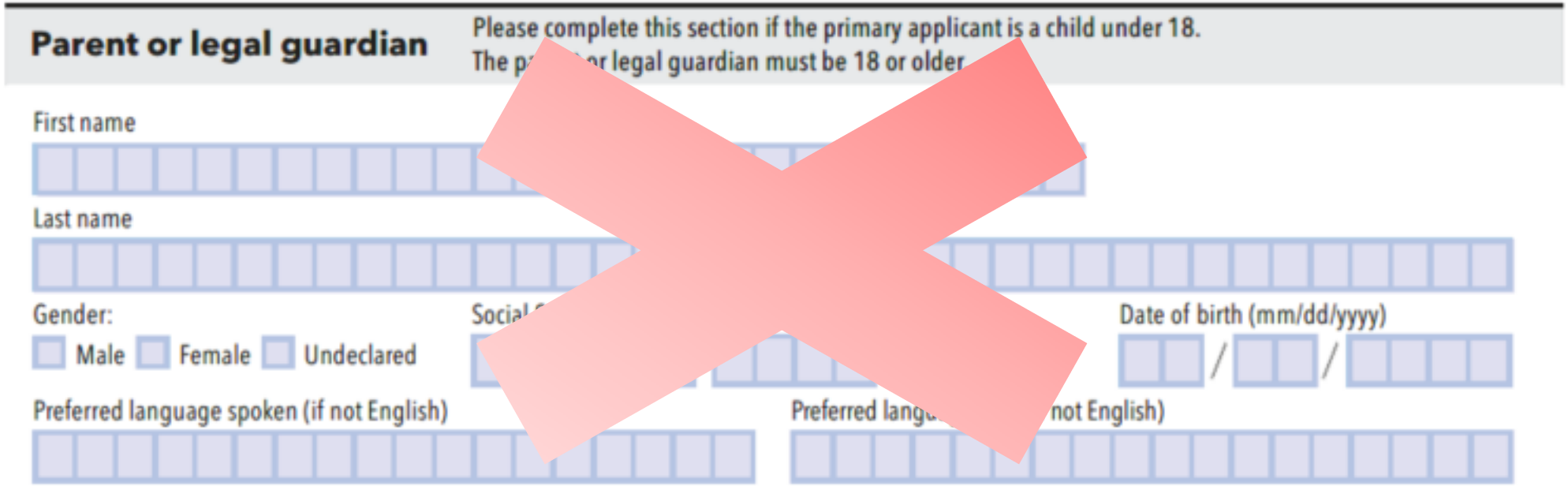
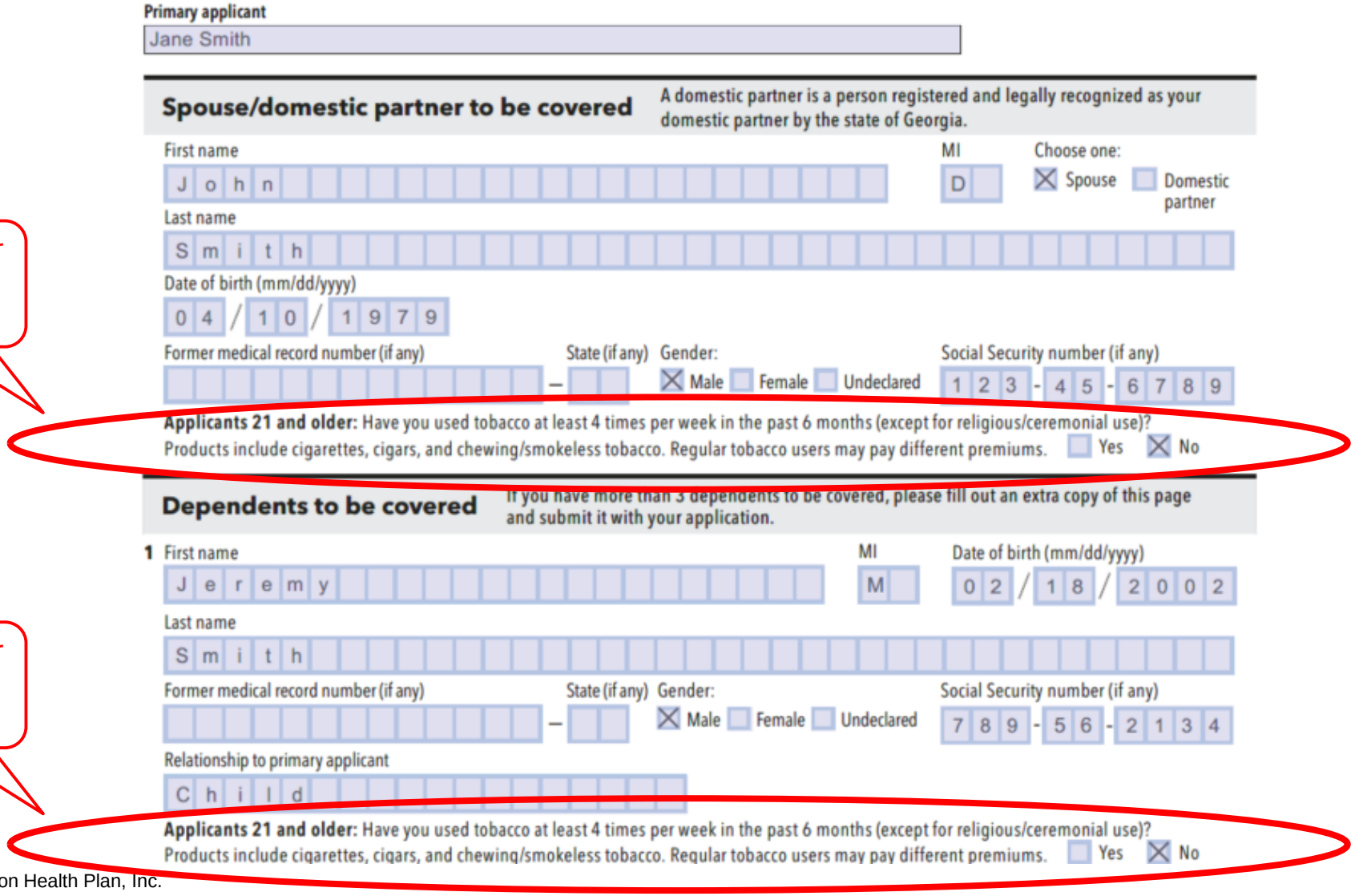
STEP 3: *(continued)*: Disregard parent or legal guardian section



STEP 3: *(continued)*: If you have a spouse/domestic partner or child dependents who need coverage, please list them on this form. The application has space for 3 dependents. If you have more than 3, fill out an extra copy of this page and submit with your application. As a reminder, spouse/domestic partner and child dependents cannot have access to other coverage to qualify.

Only answer if 21 and older

Only answer if 21 and older



Primary applicant

Jane Smith

Spouse/domestic partner to be covered

A domestic partner is a person registered and legally recognized as your domestic partner by the state of Georgia.

First name: John | MI: D | Choose one: ☒ Spouse ☐ Domestic partner

Last name: Smith

Date of birth (mm/dd/yyyy): 04 / 10 / 1979

Former medical record number (if any): – | State (if any): | Gender: ☒ Male ☐ Female ☐ Undeclared | Social Security number (if any): 123-45-6789

Applicants 21 and older: Have you used tobacco at least 4 times per week in the past 6 months (except for religious/ceremonial use)? Products include cigarettes, cigars, and chewing/smokeless tobacco. Regular tobacco users may pay different premiums. ☐ Yes ☒ No

Dependents to be covered

If you have more than 3 dependents to be covered, please fill out an extra copy of this page and submit it with your application.

1 First name: Jeremy | MI: M | Date of birth (mm/dd/yyyy): 02 / 18 / 2002

Last name: Smith

Former medical record number (if any): – | State (if any): | Gender: ☒ Male ☐ Female ☐ Undeclared | Social Security number (if any): 789-56-2134

Relationship to primary applicant: Child

Applicants 21 and older: Have you used tobacco at least 4 times per week in the past 6 months (except for religious/ceremonial use)? Products include cigarettes, cigars, and chewing/smokeless tobacco. Regular tobacco users may pay different premiums. ☐ Yes ☒ No

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Step 4 is OPTIONAL

STEP 4: Choose an authorized representative (if you have one)

You can give a trusted friend or relative permission to talk about this application with us, see your information, or act for you on matters related to this application only. This person is called an authorized representative.

First name: John

MI: D

Last name: Smith

Phone (mobile phone if available): 404-491-2156

By signing, you've appointed this person as your legally authorized representative to get official information about this application, and to act for you on matters related to this application.

X Jane Smith

Digitally signed by: Jane Smith
DN: CN = Jane Smith email = jane.smith@gmail.com C = AD
Date: 2023.10.30 12:18:25 -04'00'

Date (mm/dd/yyyy): 11/01/2023

Primary applicant (parent or legal guardian for children under 18)

STEP 5: Sign the application agreement

Important: The primary applicant must read, sign, and date below. If the primary applicant is a child under 18, then their parent or legal guardian must sign. By signing, the parent or legal guardian agrees to be responsible for paying all premiums, copays, coinsurance, and deductibles for all the applicants listed on this application. A copy of your agreement with your signature is as valid as the original. If your signature is missing, we will cancel the application. To be eligible for KPIF coverage, you and any dependent you're applying for can't be entitled to Medicare Part A or enrolled in Medicare Part B.

- I verify that no applicant listed on this form is entitled to Medicare Part A or enrolled in Medicare Part B.
- I have provided true and correct answers to all the questions on this form to the best of my knowledge.
- If I worked with a broker, I permit Kaiser Permanente to share the enrollment and disenrollment information listed on this application with them. I understand that the broker or Kaiser Permanente representative may get financial and/or nonfinancial payments from Kaiser Permanente because they assisted me with this application.
- I know that my information on this form will only be used to determine ongoing eligibility for health coverage and will be kept private as required by law.
- By providing my email address and mobile phone number, I am agreeing to receive email and text communications from Kaiser Permanente.

Step 5 is REQUIRED

X Jane Smith

Digitally signed by: Jane Smith
DN: CN = Jane Smith email = jane.smith@gmail.com C = AD
Date: 2023.10.30 13:33:53 -04'00'

Date (mm/dd/yyyy): 11/01/2023

Primary applicant (parent or legal guardian for children under 18)

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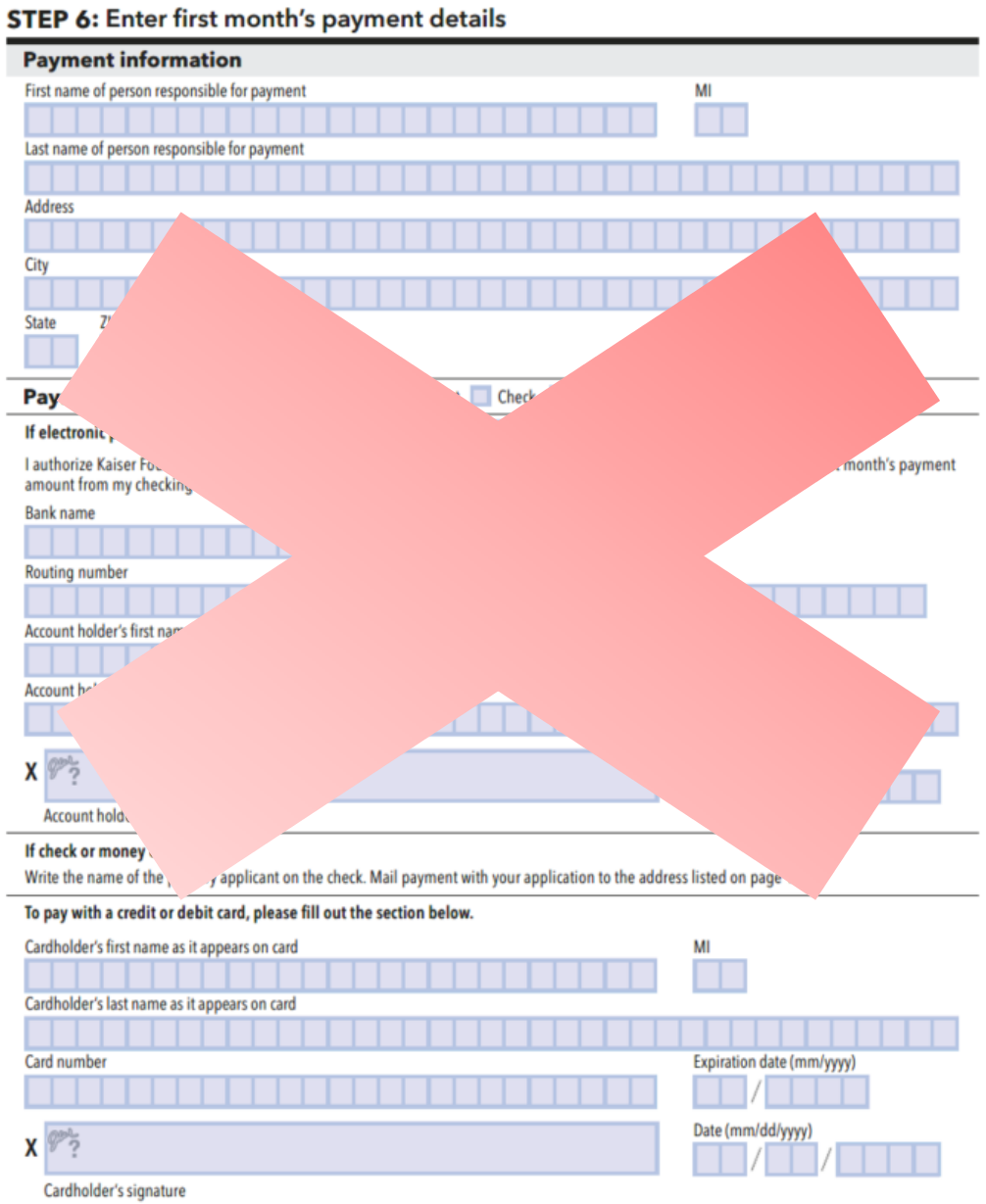
Disregard Step 6 (pages 6, 7, & 8)



STEP 6: Enter first month's payment details

Payment information

First name of person responsible for payment

MI

Last name of person responsible for payment

Address

City

State

Pay

Check

If electronic

I authorize Kaiser Fo

month's payment

amount from my checkin

Bank name

Routing number

Account holder's first na

Account h

X

Account hold

If check or money

Write the name of the

applicant on the check. Mail payment with your application to the address listed on page

To pay with a credit or debit card, please fill out the section below.

Cardholder's first name as it appears on card

MI

Cardholder's last name as it appears on card

Card number

Expiration date (mm/yyyy)

/

X

Date (mm/dd/yyyy)

/ /

Cardholder's signature

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Georgia Bridge Program
Application for subsidy – 2024

Use this form to apply for a subsidy to pay your monthly premiums and most out-of-pocket costs under the Kaiser Permanente KP GA Gold 500 Ded/500 Rx Ded / KP GA Signature Gold 500 Ded/500 Rx Ded. There is no cost to apply.

Enrollment in Kaiser Permanente's Georgia Bridge Program is available during the Individuals and Families annual open enrollment and special enrollment periods. The special enrollment period generally lasts 60 days from the date of your qualifying life event. Some qualifying life events allow more than 60 days from the date of your qualifying life event. Visit **kp.org/chcspecialenrollment** for more information. To apply, follow these steps:

Step 1: Fill out the Application for subsidy form

- Type or print using black or blue ink.
- Answer all questions completely.
- Sign the form.
- Make a copy of the completed form for your records.

Step 2: Fill out the separate Kaiser Permanente Application for health coverage.

Step 3: Include proof of income

Attach copies of the most current proof of your household's gross income:

- If employer paid – include your last 2 paycheck stubs, W-2, or pay 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.
- 1040 tax form from previous year – if you submit your 1040 tax form, no other proof of income is required.
- See Section 4 for more examples of proof of income.

If your household has income deductions, provide proof such as:

- Student loan interest – include your last student loan statement.
- Self-employed – Schedule C and page 1 (the adjusted gross income page) of last year's federal income tax return or a profit and loss form.

Eligibility rules:

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

- The primary applicant needs to be actively enrolled with a participating community partner.
- Live in Kaiser Permanente's metro Atlanta 20-county service area.*
- Live in a household with an income less than 100% of the federal poverty level.
- Not be eligible for other public or private health coverage such as, but not limited to, Medicaid, Peach Care for Kids®, Medicare, a job-based health plan, or financial help through the health benefit exchange.
- All child dependents must be younger than 26.

*Bartow, Butts, Cherokee, Clayton, Cobb, Coweta, DeKalb, Douglas, Fayette, Forsyth, Fulton, Gwinnett, Henry, Lamar, Newton, Paulding, Pike, Rockdale, Spalding, and Walton counties

You do NOT have to be a U.S. citizen to be eligible for Kaiser Permanente's Georgia Bridge Program.

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Email is the preferred method of submission. Please refer to the "Bridge Program Application Submission Tip Sheet" PDF for how to complete the applications electronically, scan documents, and email.

Step 4: Include additional documents

- GA: Community partner verification form. Contact a participating community partner for assistance.
- Medicaid or PeachCare for Kids® and/or health benefit exchange denial letters if applicable.
- Provide proof of guardianship if applicable.
- Other information or documentation that may help us evaluate your eligibility.

Step 5: Send your forms, proof of income, and all other required documents

Send your completed and signed **Application for subsidy,** Application for health coverage, proof of current income, income deductions, and other required documents through one of the following options:

- By email:
  CHC-Applications@kp.org
  (Include "application" in the subject line)
- By mail:
  Kaiser Permanente
  Attn: CHC
  P.O. Box 23127
  San Diego, CA 92193-3127
- By fax:
  1-855-355-5334

We're here to help:

If you have questions about the Georgia Bridge Program or about this form, please call us at:
1-888-865-5813 (TTY **711**)
Monday through Friday,
7 a.m. to 7 p.m. Eastern time
(closed major holidays).

Please note: Continued eligibility for the Georgia Bridge Program is not guaranteed. We reserve the right to close enrollment or change the eligibility rules at any time. If you are approved for the subsidy, the subsidy period is limited and we will contact you in the future to confirm that you still qualify.

Kaiser Permanente will keep your information private, as required by law, and use your personal information only to see if you qualify for Kaiser Permanente's subsidy.

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 other purpose required by law.

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SECTION 1: Applicant information (Required)

Primary applicant — The person who will be covered by the health plan and applying for the Georgia Bridge Program subsidy. If applying for a child under 18, the parent or legal guardian should provide the child's information below. The parent or legal guardian information should be filled out in Section 2.

First name*: Jane | MI: R

Last name*: Smith | Date of birth* (mm/dd/yyyy): 08 / 07 / 1980

Medical record number (if available):

Gender*: ☐ Male ☒ Female ☐ Undeclared

Home phone: 404-467-7891 | Mobile phone:

Home address* (Include Apt. Number. No P. O. boxes, please): 1234 Main Street

City*: Atlanta | State*: GA | ZIP code*: 30317

Mailing address (If different than home address. Include apt. number.):

City | State | ZIP code

Email: jane.smith@gmail.com

Providing your email address is HIGHLY encouraged

Please answer **ALL** applicable questions below about the primary applicant. This information is only used to find out if the primary applicant is eligible for the Georgia Bridge Program or other programs that provide health coverage.

Is the primary applicant…

Offered health coverage through an employer?*	☐ Yes ☒ No
GA: Over 18 and, on average, works more than 80 hours a month?*	☐ Yes ☒ No
A U.S. citizen?* If you answered yes, skip the following two questions.	☒ Yes ☐ No
A Lawful Permanent Resident[1]?	☐ Yes ☐ No
If yes, how many years have they been a Lawful Permanent Resident[1]?	

*Indicates a required field

1. A Lawful Permanent Resident (LPR) is not a U.S. citizen. An LPR is an immigrant who resides in the U.S. under a legally recognized permanent residence status. Examples include Green Card Holders, Permanent Resident Aliens, and Resident Alien Permit Holders.

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SECTION 2: Parent or legal guardian (if applicable)

Only complete this section if [illegible] parent or legal guardian applying [illegible] child under 18.

First name

MI

Last name

Date of birth (mm/dd/yyyy)

Gender

Male Female Undeclared

Mobile phone

Mailing address (Include Apt. N

City

State

ZIP code

Email

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SECTION 3: Family information (if applicable)

Spouse/domestic partner to be covered (if applicable)

Please complete this section for the spouse/domestic partner who will be covered by the health plan and applying for the Georgia Bridge Program subsidy. If an applicant is under 18, the parent or legal guardian should complete this section for the applicant.

First name: John

MI: D

Choose one: [X] Spouse [ ] Domestic partner

Last name: Smith

Date of birth (mm/dd/yyyy): 04 / 10 / 1979

Medical record number (if available):

Gender: [X] Male [ ] Female [ ] Undeclared

Please answer **ALL** applicable questions below about the spouse/domestic partner. This information is only used to find out if the spouse/domestic partner is eligible for the Georgia Bridge Program or other programs that provide health coverage.

Is the spouse/domestic partner …

Offered health coverage through an employer?*	[ ] Yes [X] No
GA: Over 18 and, on average, works more than 80 hours a month?*	[ ] Yes [X] No
A U.S. citizen? If you answered yes, skip the following two questions.	[X] Yes [ ] No
A Lawful Permanent Resident[1]?	[ ] Yes [ ] No
If yes, how many years have they been a Lawful Permanent Resident[1]?	

(continues)

1. A Lawful Permanent Resident (LPR) is not a U.S. citizen. An LPR is an immigrant who resides in the U.S. under a legally recognized permanent residence status. Examples include Green Card Holders, Permanent Resident Aliens, and Resident Alien Permit Holders.

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SECTION 3: Family information *(continued)*

Dependent 1 to be covered

Please complete this section for each additional dependent who will be covered by the health plan and applying for the Georgia Bridge Program subsidy. If an applicant is under 18, the parent or legal guardian should complete this section for the applicant. If you have more than 3 dependents applying, please copy this page and fill out the same information requested below for each additional dependent.

First name: Jeremy

MI: M

Last name: Smith

Date of birth (mm/dd/yyyy): 02 / 18 / 2002

Medical record number (if available):

Gender: [X] Male [ ] Female [ ] Undeclared

Relationship to primary applicant: Child

Please answer **ALL** applicable questions below about the dependent. This information is only used to find out if the dependent is eligible for the Georgia Bridge Program or other programs that provide health coverage.

Is the dependent …

Offered health coverage through an employer?*	[ ] Yes [X] No
GA: Over 18 and, on average, works more than 80 hours a month?*	[ ] Yes [X] No
A U.S. citizen?	[X] Yes [ ] No
If you answered yes, skip the following two questions.	
A Lawful Permanent Resident[1]?	[ ] Yes [ ] No
If yes, how many years have they been a Lawful Permanent Resident[1]?	

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SECTION 4: Household income (Required)

Your family size and household income help us determine if you are eligible for the Georgia Bridge Program.

(A) What is the total number of family members† in your household?* 3

†If you file taxes, this is the same number of family members that you report on your tax form. (You do not need to file taxes to apply.) Usually, this includes yourself and the immediate family members who live with you such as your spouse and your children 18 and under (up to 23 if a student).

(B) How many of the family members counted in (A) contribute to your household/family income?* 2

(C) Please complete the table below.

- List the estimated yearly gross income (before taxes) for each family member counted in (B).
- If (B) is more than 3, make a copy of this page, provide the same information for each additional family member, and send it with your application.
- For child dependents who are working but whose income is below the threshold required for filing taxes ($12,950 in 2022):
  - Do not include them in the number of family members who contribute to household/family income
  - Do not include their income in the chart below
  - Do not submit proof of income documents

Estimated yearly income (before taxes)	family member 1	family member 2	family member 3
Income from wages, tips, and self-employment income	$ 0	$ 14,000	$
Social Security Disability (SSDI) payments	$ 10,500	$ 0	$
Unemployment benefits	$ 0	$ 0	$
Pension/retirement income	$ 0	$ 0	$
Rental income you get from property you own and lease	$ 0	$ 0	$
Interest income and annuities	$ 0	$ 0	$
Student financial aid – only include if used for living expenses (scholarships, awards, grants for tuition/education expenses are not counted as income)	$ 0	$ 0	$
Alimony received (for settlements before 2019)	$ 0	$ 0	$
Other income, such as capital gains, clergy earnings, or gambling income	$ 0	$ 0	$
TOTAL INCOME	$ 10,500 *	$ 14,000	$

Attach copies of the most current proof of income for the items you include in the table above.
Examples include:

- Pay stubs
- Award letters for Social Security or unemployment benefits
- 1040 tax form from previous year
- W-2 from current employer
- Letter from employer

We will calculate your total yearly household income by adding up the amounts shown in your submitted proof of income documents. If you submitted your 1040 tax form, no other proof of income is required. If your proof of income documents don't match the yearly gross income in the table above, please explain any special circumstances that we should consider when we are reviewing your income documents:

☐ Only myself/my spouse works ☐ Hours have been cut or are not consistent ☐ Recent job change
☐ I do not work ☐ Self employed ☐ Other (please explain) _____

If you indicated 1 or more family members contribute to your household/family income, you must complete this chart with the **estimated YEARLY GROSS income** and submit proof of income for all family members.

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Section 4: Household Income *(continued)*: Only complete this chart if you have items to deduct. Living expenses are not considered deductions

SECTION 4: Household income *(continued)*

If any family member included in table (C) has income deductions, please complete the table below.

Estimated yearly income deductions	family member 1	family member 2	family member 3
Student loan interest	$	$	$
Self-employed expenses	$	$	$
Alimony paid (for settlements before 2019)	$	$	$
Other deductions: Please specify	$	$	$
TOTAL DEDUCTIONS	$	$	$

Attach copies of the most current proof of deductions for the items listed above (examples: student loan statement, self-employment receipts). **We will calculate the total deductions by adding up the proof of deductions documents. If your proof of deductions doesn't match the total deductions in the above table, please explain in the space provided on page 9.**

Self-employment: If any family member included in table (C) is self-employed, 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.

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Section 5 is OPTIONAL

Section 6 is REQUIRED

SECTION 5: Choose an authorized representative (if you have one)

You can give a community partner/agency, representative, relative, or trusted friend permission to talk about this form with us, see your information, or act for you on matters related to this form only. This person or community partner/agency is called an authorized representative.

First name: John

MI: D

Last name: Smith

Organization name (if applicable):

Kaiser Permanente entity enrollment number (if applicable):

Phone: 404-491-2156

By signing, you've appointed this person or community partner/agency as your legally authorized representative to get information for this Kaiser Permanente form and to act for you on matters related to this form. This authorization lasts two (2) years from your signature date or until you cancel it. You may cancel the authorization at any time by submitting a signed written request to Kaiser Permanente, Attn: CHC, P.O. Box 23127, San Diego, CA 92193-3127 or fax: 1-855-355-5334. Once you cancel, we will stop sharing your information and no longer use it, except to the extent that the information has been relied upon before. Once we disclose to your representative, your information may be redisclosed by your representative and no longer protected by federal privacy law. Even if you don't sign this authorization, we will still process your application for the Georgia Bridge Program subsidy but we will not be able to share your information with your representative. You have a right to receive a copy of this authorization.

X Jane Smith

Digitally signed by: Jane Smith
DN: CN = Jane Smith email = jane.smith@gmail.com C = AD
Date: 2023.11.01 12:21:14 -04'00'

Date (mm/dd/yyyy): 11/01/2023

Required signature (primary member or financially responsible party, parent or legal guardian for members under 18)

SECTION 6: Sign the application agreement (Required)

By signing this form, you certify the information on this form is correct and accurate. If you provide 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.

X Jane Smith

Digitally signed by: Jane Smith
DN: CN = Jane Smith email = jane.smith@gmail.com C = AD
Date: 2023.11.01 12:24:16 -04'00'

Date (mm/dd/yyyy): 11/01/2023

Required signature (primary member or financially responsible party, parent or legal guardian for members under 18)

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Application Recap

Kaiser Permanente for Individuals and Families (KPIF) Application	Kaiser Permanente Community Health Subsidy Application
PAGES 2 – 5: Please print ‘Primary Applicant’ name at the top of pages 2 – 5. STEP 1: Select Open enrollment if applying between 11/1/2023 – 1/15/2024 and skip to Step 2. STEP 2: Select KP GA Gold 500 Ded/500 Rx Ded and KP GA Signature Gold 500 Ded/500 Rx Ded. Do NOT select any other plan. STEP 3: Complete only for family members requesting coverage; including yourself (allows for up to 3 child dependents). Disregard ‘Parent or legal guardian’; the primary applicant for the Bridge Program must be age 18 or above. STEP 4: This step is required ***only if*** you would like someone to act for you in matters related to this application. STEP 5: The primary applicant must sign and date. Failure to do so will delay the processing of your application. STEP 6: Please disregard.	SECTION 1: Primary applicant information SECTION 2: Parent or legal guardian – please disregard SECTION 3: Family information if applying for coverage (allows for up to 3 child dependents) SECTION 4: Household income – verify family size, income and expenses • Family size includes all members in household, including those that are not applying for coverage. • Household income includes all income from the family (self, spouse, minor dependents/those claimed on tax return). SECTION 5: Authorized Representative • Include an authorized representative ***only if*** you would like someone to act on your behalf for matters pertaining to enrollment in the Bridge Program. SECTION 6: Certification • The primary applicant must sign and date.

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Thank you

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