Georgia Bridge Program
Subsidy Eligibility Form – 2019

Use this form to apply for 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 / GA Gold 500/20 plan.

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 qualifying life event such as marriage, birth or adoption of a child, divorce, or loss of job and job-based health coverage. To apply, follow these steps:

Step 1: Fill out the Subsidy Eligibility Form
- Use only black or blue ink to complete the form.
- Answer all questions completely.
- Sign the form.
- Provide proof of guardianship if applicable.
- Make a copy of the completed form for your records.

Step 2: Apply for Health Coverage
Complete 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.
- See Section 4 of this form for more examples of proof of income. If you have received an affordability exemption from the federal government, please include a copy of the exemption letter.

We’re here to help:
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 / GA Gold 500/20 plan. Plan enrollment will depend on your home ZIP code.

The Kaiser Permanente subsidy is offered as part of Kaiser Permanente’s Georgia Bridge Program. Eligibility for the program will be considered for individuals who are uninsured and:
- Are actively enrolled in a training program with a participating community partner
- Live in Kaiser Permanente’s metro Atlanta 20-county service area*
- Live in a household with incomes below 100% of the federal poverty level
- Do not have access to any other public or private health coverage, including, but not limited to, Medicaid, PeachCare for Kids, Medicare, job-based coverage, or coverage through the Georgia Health Insurance Exchange
- Are age 64 or younger, and all child dependents must be younger than 26
- Have not been previously enrolled in the Georgia Bridge Program

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

- Student loan interest – include your last student loan statement
- Alimony paid – include a copy of your check
- Self-employed – include all receipts

**Step 4: Mail your forms and proof of income**

Mail your completed Subsidy Eligibility Form, Kaiser Permanente Application for Health Coverage, proof of current income, and any income deductions to:

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

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

**We’re here to help:**

If you have any questions about Georgia Bridge Program or about this form, please call Member Services at:

1-888-865-5813 (TTY 711)

Monday through Friday, 7 a.m. to 7 p.m. Eastern time (ET).

Eligibility rules for Kaiser Permanente’s Georgia Bridge Program may change at any time.

This Georgia Bridge Program subsidy is limited and subject to availability.

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**Please note:** 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 any other purpose required by law.
Frequently asked questions

1. How long does it take to determine eligibility for Kaiser Permanente’s Georgia Bridge Program?
   Completed forms that include all required documentation can take up to 30 business days to process. If information is missing, it may take longer than 30 days and you may miss the deadline for applying. 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 the 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 / 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 end your membership or until you fail to pay the full premium.

5. What other health coverage programs are available?
   • Consider Medicaid or PeachCare for Kids. This option may be available if you were born in the United States, you are a legal resident, and you meet certain eligibility requirements such as: children, seniors, and people with disabilities, and pregnant women under the age of 65 with income up to 247% of the federal poverty level (for example: $29,986 for an individual, or $61,997 for a family of 4, per 2018 guidelines). Kaiser Permanente is a Medicaid provider and may be available to you. Please visit kp.org/medicaid/ga for more information.
   • Buy health coverage through your state’s Health Insurance Marketplace (also known as the Exchange). If you qualify, you may get help paying for your plan premiums or out-of-pocket costs. For more information visit HealthCare.gov.
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SECTION 1: Parent or legal guardian (if the primary applicant is a child under 18)

First name

Last name

Date of birth (mm/dd/yyyy)

Gender

Male    Female

Mailing address (P.O. boxes acceptable)

City

State

ZIP code

Phone

SECTION 2: Applicant information

Primary applicant

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.

First name

Last name

Date of birth (mm/dd/yyyy)

Gender

Male    Female

Health record number (if any)

Mailing address (no P.O. boxes, please)

City

State

ZIP code

Home phone

Email address (optional)

Mobile phone

(continues)
### SECTION 2: Applicant information

Please answer the following questions about the primary applicant who will be covered by the health plan. 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 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 member been a legal permanent resident?
- 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

Please complete this section for each additional family member applying for 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>Family member 1</th>
<th>First name</th>
<th>MI</th>
<th>Last name</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- Date of birth (mm/dd/yyyy) [ ]/[ ]/[ ]
- Gender [Male] [Female]
- Health record number (if any) [ ]
- Relationship to primary applicant [ ]

Please answer the following questions about the family member. This information is only used to find out if the family member is eligible for the Georgia Bridge Program or other programs that provide health coverage. 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?
- 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)

<table>
<thead>
<tr>
<th>Family member 2</th>
<th>Please complete this section for each additional family member applying for the Georgia Bridge Program subsidy. If an applicant is under 18, the parent/guardian should complete this section for the applicant.</th>
</tr>
</thead>
<tbody>
<tr>
<td>First name</td>
<td>MI</td>
</tr>
<tr>
<td>Last name</td>
<td></td>
</tr>
<tr>
<td>Date of birth (mm/dd/yyyy)</td>
<td>Gender</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Please answer the following questions about the family member. This information is only used to find out if the family member is eligible for the Georgia Bridge Program or other programs that provide health coverage. Is the family member who will be covered by the health plan …</td>
<td></td>
</tr>
<tr>
<td>A U.S. citizen?</td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>A legal permanent resident?</td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>Currently receiving or have access to a job-based health plan or another health plan?</td>
<td>□ Yes □ No</td>
</tr>
</tbody>
</table>
### SECTION 3: Family information (continued)

<table>
<thead>
<tr>
<th>Family member 3</th>
<th>Please complete this section for each additional family member applying for the Georgia Bridge Program subsidy. If an applicant is under 18, the parent/guardian should complete this section for the applicant.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>First name</strong></td>
<td>MI</td>
</tr>
<tr>
<td><strong>Last name</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Date of birth (mm/dd/yyyy)</strong></td>
<td><strong>Gender</strong></td>
</tr>
<tr>
<td><strong>Relationship to primary applicant</strong></td>
<td></td>
</tr>
</tbody>
</table>

Please answer the following questions about the family member. This information is only used to find out if the family member is eligible for the Georgia Bridge Program or other programs that provide health coverage. 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?
- 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)

<table>
<thead>
<tr>
<th>Family member 4</th>
<th>Please complete this section for each additional family member applying for the Georgia Bridge Program subsidy. If an applicant is under 18, the parent/guardian should complete this section for the applicant.</th>
</tr>
</thead>
<tbody>
<tr>
<td>First name</td>
<td>MI</td>
</tr>
<tr>
<td>Last name</td>
<td></td>
</tr>
<tr>
<td>Date of birth (mm/dd/yyyy)</td>
<td>Gender</td>
</tr>
<tr>
<td></td>
<td>Male</td>
</tr>
<tr>
<td>Relationship to primary applicant</td>
<td></td>
</tr>
</tbody>
</table>

Please answer the following questions about the family member. This information is only used to find out if the family member is eligible for the Georgia Bridge Program or other programs that provide health coverage. 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? [ ] 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

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

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

What is the total number of people in your household, including yourself? __________
Include yourself, your spouse if you have one, and any dependents that you would include in your tax filing. (You do not need to file taxes to apply for the Georgia Bridge Program.)

How many people in the household help contribute to the household/family income? __________
Please complete the table below.

• List the estimated yearly gross income (before taxes) for each person who contributes to your total household income.
• If an item doesn’t apply, write “N/A” (not applicable).
• If more than 3 people contribute to your total household income, make a copy of this page, provide the same information for each additional person, and send it with your application.

<table>
<thead>
<tr>
<th>Estimated yearly gross income (before taxes)</th>
<th>Person 1</th>
<th>Person 2</th>
<th>Person 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gross income from wages, tips</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>Social Security Disability (SSDI) payments</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>Alimony/spousal support received</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>Unemployment benefits</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>Pension/retirement income</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>Rental income you get from property you own and lease</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>Interest income</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>Student financial aid – only include if used for living expenses (scholarships, awards, grants for tuition/education expenses are not counted as income)</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>Other income</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
</tbody>
</table>

Attach copies of the most current proof of income for all the items listed 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
• A bank statement

(continues)
### SECTION 4: Household income (continued)

If anyone in your household has income deductions, please complete the table below.

<table>
<thead>
<tr>
<th>Estimated yearly income deductions</th>
<th>Person 1</th>
<th>Person 2</th>
<th>Person 3</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>$</td>
</tr>
<tr>
<td>Other deductions: Please specify</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
</tbody>
</table>

Attach copies of the most current proof of deductions for the items listed above (examples: student loan statement, copy of alimony check, self-employment receipts).

**Self-employment**: If anyone in your household 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.
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.

Date (mm/dd/yyyy) X / / 

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

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 is called an authorized representative.

Please be sure to provide the name of the same authorized representative you listed on the Kaiser Permanente Application for Health Coverage.

First name Last name

Organization name (if applicable)

Kaiser Permanente entity enrollment number (if applicable) Phone

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

Date (mm/dd/yyyy) X / / 

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

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