Medical Financial Assistance

Southern Colorado Area

KAISER PERMANENTE®

Medical Financial Assistance

You may be eligible for a medical

As a nonprofit health plan, Kaiser Permanente strives to support our patients, and in some cases that means locating assistance programs for medical services for eligible patients in need. You may be eligible for a government medical assistance program or a Kaiser Permanente sponsored financial assistance program.

Medical Financial Assistance Program

You may apply directly for Kaiser Permanente's Medical Financial Assistance (MFA) program. This is a Kaiser Permanente program based on the availability of funds which provides financial assistance for medically necessary services provided by Kaiser Permanente and or approved contracted providers in your area.*

To apply for financial assistance you must complete and submit the enclosed application and meet the following eligibility criteria:

- Separate from your MFA application, you must access or apply for other assistance programs outside of Kaiser Permanente for which you may be eligible, such as Medicaid or the Medicare Low-Income Subsidy program. As part of your MFA application, you may be required to submit documentation of your application, approval, or denial to any outside resources for which you applied.
- If you do not meet the income criteria for financial assistance, but have circumstances due to unusually high medical costs or a catastrophic event, you also may be eligible.

financial assistance program.

Documentation required:

- Copies of the two most recent paycheck stubs for all adult members of your household (a year-to-date total must be included on the paycheck for all members aged 18 and older).
- Copies of the most recent signed federal or state tax returns for your household.
- Copies of other documents to verify household income. This includes, but is not limited to, letters from the Office on Disability, Social Security, or an unemployment office.
- Copies of the two most recent bank statements for all checking, savings, or investment accounts held by adults in your household.
- Information on all homes currently owned by any adult member of your household.

Please send photocopies only. Copies and/or originals will not be returned.

NOTE: Should you currently have a health savings account with any balance, you are not eligible for financial assistance and do not need to complete this application.

*For example: Ongoing office visits and prescription medications. For more information on what medical services are covered by this program, please call the Medical Financial Assistance department at **1-866-899-6018** or **1-800-659-2656** (TTY for the deaf, hard of hearing, or speech impaired), Monday – Friday, 8 a.m. – 5 p.m.

APPLICATION

Each individual applying for financial assistance should submit a separate application and complete all fields. If you have been approved in the past, you must wait 12 months after your last award expiration date to re-apply.

How did you learn about this program?

- ❑ Physician's office: _____
- ❑ Kaiser Permanente medical office: _____
- ❑ Other: _____

Please fill out all information.

Kaiser Permanente Health Record ID Number: _____
Name: _____
Primary Phone: _____
Address: _____
If applicable, Power of Attorney/Parent: _____
_____
Is it OK to leave messages? ____yes ____no

Services Requested: *Please check all that apply.*

__Physician Office Visits (one time or ongoing)
__Prescription Medications
Other:_____

Employment Status

APPLICANT:

Currently employed? __yes ___no
Do you have a disability? ___yes ___no
Have you applied for Medicaid? ___yes ___no

NOTE: Please submit a separate application for each applicant.

_____
_____
_____

_____

Date of Birth: _____
Other Phone: _____
City, St, Zip: _____
Power of Attorney/Parent Phone: _____
_____
Your Preferred Language: _____

OTHER HOUSEHOLD MEMBER:
Currently employed? ___yes ___no
Does he/she have a disability? ___yes ___no

OTHER HOUSEHOLD MEMBER:
Currently employed? __yes ___no
Does he/she have a disability? ___yes ___no

Household Monthly Income

Include all adult members of the household (which is defined as anyone living in your home older than the age of 18 who does not pay your head of household a monthly rent payment). All other household members must provide financial documentation for complete family income. Failure to submit full family financial documentation may delay processing of your application.

Monthly Income Source	APPLICANT
(example)	$____800_____
Salary/Wages	$_____
Alimony/Child Support	$_____
Pension Income	$_____
Rental Income from Second Property	$_____
Social Security/SSI/SSDI*	$_____
Other	$_____
MONTHLY GROSS INCOME	$_____

Full documentation is defined as the past two months' pay stubs with a year-to-date total for all adult household members, and your federal and state tax return documents from the most recent year.

How many people live in your household over the age 18? _____
How many people live in your household under the age 18? _____

Other household member	Other household member
$_____200_____	$___1,200____
$_____	$_____
$_____	$_____
$_____	$_____
$_____	$_____
$_____	$_____
$_____	$_____
$_____	$_____

*SSI is Social Security Income.
SSDI is Social Security Disability Income.

Current Household Assets

Include all 'other' adult household members' assets as well as the applicants'. All financial documentation must be provided for complete family assets. Failure to submit full family financial documentation may delay processing of your application. **Full documentation is defined as the last two months' statements, all pages unaltered, with the financial institution's logo clearly printed on the document for all adult household members.**

Please fill out the information below with the balance in that corresponding account.

Current Asset Accounts	Applicant
(example)	$____800_____
Checking Account	$_____
Savings Account	$_____
CD (Certificate of Deposit)	$_____
Stocks & Mutual Funds	$_____
Life Insurance with cash value	$_____
Other	$_____
CURRENT TOTAL ASSETS	$_____

Do you own property that you don't live in?
___yes ___no
If yes, please attach supporting value documentation: $_____

Do you own rental property?
___yes ___no
If yes, please attach supporting value documentation: $_____

Other household member	Other household member
$_____200_____	$___1,200____
$_____	$_____
$_____	$_____
$_____	$_____
$_____	$_____
$_____	$_____
$_____	$_____
$_____	$_____

Applicant's Average Monthly Medical Expenses

Prescriptions
Physician Office Visits
Other
Medical Insurance Premiums (your portion)

Financial agreement and credit report authorization

You warrant the truth of the information submitted on this application and hereby authorize our employees and agents to investigate and verify any information provided to us by you. Eligibility requirements include income, assets, and existing medical expenses. By signing below, you are granting permission to Kaiser Permanente to obtain your credit report from one or more consumer reporting agencies. You acknowledge receipt of a copy of this agreement and promise to pay all amounts owed, by the applicant, that are covered under its terms. Incomplete applications will result in a delay in processing. Applicant/Power of Attorney will be notified, by mail or phone, whether the application is approved or denied.

_____

Signature of Applicant/Guardian Date

_____

Signature of 'other' Household Member Date

$_____
$_____
$_____
$_____

Submitting your application

Please send your completed application with all appropriate supporting documentation to:

Kaiser Permanente Colorado
Medical Financial Assistance Department
Post Office Box 378066
Denver, Colorado 80237

If you have any questions or require assistance with this application, please call **1-866-899-6018** or **1-800-659-2656** (TTY), Monday – Friday, 8 a.m. – 5 p.m.

Appeals

If your application is denied, you may appeal the decision. You may obtain a *Denial Appeal Form* by calling **1-866-899-6018** or **1-800-659-2656** (TTY), Monday – Friday, 8 a.m. – 5 p.m. Please send your completed form to the Medical Financial Assistance department at the address listed above. You will receive a response within 30 days.

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This section to be completed by Kaiser Permanente MFA staff:

Additional Patient Information:

SSN:

KP group#:

Coverage type:

Medicare LIS:

Case Details:

Open Notes:

Referred to:

Disposition MFAP case entry:_____

Total award amount:_____

Pharmacy award amount:_____

Case closed in MFAP:

(signature & date)_____

If approved, entry into HC:

(signature & date)_____