

# Kaiser Permanente Medical Financial Assistance (MFA) Program

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## HELP IN YOUR LANGUAGE

**English:** This is important information from Kaiser Permanente. If you need help understanding this information, please call **1-800-777-7902** and ask for language assistance. Help is available 24 hours a day, 7 days a week, excluding holidays.

**Chinese:** 這是來自Kaiser Permanente的重要資訊。如果您需要協助瞭解此資訊，請致電**1-800-777-7902**尋求語言協助。我們每週7天，每天24小時皆提供協助（節假日休息）。

**Spanish:** La presente incluye información importante de Kaiser Permanente. Si necesita ayuda para entender esta información, llame al **1-800-777-7902** y pida ayuda lingüística. Hay ayuda disponible 24 horas al día, siete días a la semana, excluidos los días festivos.

# Kaiser Permanente Medical Financial Assistance (MFA) Program

If you need help paying for health care services or prescriptions you've had, or are scheduled to receive, from Kaiser Permanente, our MFA program may be able to help you.

## How the program works

- The program offers temporary “awards” to help qualified applicants pay for care based on their financial needs.
- It's available to all Kaiser Permanente patients, whether you're a member or not.
- If awarded, the program will cover emergency or medically necessary care from Kaiser Permanente providers or at Kaiser Permanente facilities for a specified time period.
- The award does not apply to health care services provided and billed outside of Kaiser Permanente.

## How to qualify

To qualify, you must meet **ONE** of the following sets of criteria:

1. Your gross household income is no more than 300% of the federal poverty level.

OR

2. Your out-of-pocket health care costs for emergency or medically necessary care, dental care, and medication over a 12-month period are equal to or more than 10% of your gross household income.
  - Out-of-pocket costs include copays, coinsurance, and deductible payments.
  - Out-of-pocket costs do not include any payments for your health plan itself, like your monthly premium.

**If you don't have health insurance, you may be required to apply for it.**

- Because the MFA program only provides temporary financial awards, we may require you to apply for coverage that will cover you in the long term. This could include any other public or private health programs you're eligible for — like Medicaid or subsidized plans available on the health insurance marketplaces.
- We may ask you to show proof that you've applied to these programs, or that you've been approved or denied by them. But you may still be able to get financial help from the MFA program while waiting for a decision from these other programs.

2023 Federal Poverty Guidelines (FPG)		
If your household or family size is:	100% award for gross monthly household income at or below 200% of FPG	50% award for gross monthly household income between 201% and 300% of FPG
1	Up to \$2,430	\$2,431 to \$3,645
2	Up to \$3,287	\$3,288 to \$4,930
3	Up to \$4,143	\$4,144 to \$6,215
4	Up to \$5,000	\$5,001 to \$7,500
5	Up to \$5,857	\$5,858 to \$8,785
6	Up to \$6,713	\$6,714 to \$10,070

Visit [aspe.hhs.gov/poverty](https://aspe.hhs.gov/poverty) to find the guidelines for larger households.





### Have questions?

For more information about qualifying for the MFA program, or to see which health care services it pays for, visit [www.kp.org/mfa/mas](https://www.kp.org/mfa/mas) or call **1-844-412-0919** (TTY 711).

For more information about health care coverage, call us at **1-800-479-5764** (TTY 711).

## How to apply

If you meet the eligibility requirements, you can apply in any of these ways.

 <b>Online</b>	<ul style="list-style-type: none"><li>• Complete the MFA application online <a href="http://www.kp.org/mfa/mas">www.kp.org/mfa/mas</a></li><li>• Be prepared to provide all the information listed on the MFA application on the next page.</li></ul>
 <b>Fax it</b>	<ul style="list-style-type: none"><li>• Complete the MFA application on the following page.</li><li>• Fax your completed application to <b>1-855-414-1713</b>.</li></ul>
 <b>Mail it</b>	<ul style="list-style-type: none"><li>• Complete the MFA application on the following page.</li><li>• Mail your completed application to: Kaiser Permanente MFA Program 2101 East Jefferson Street Rockville, MD 20852</li></ul>
 <b>Drop it off</b>	<ul style="list-style-type: none"><li>• Complete the MFA application on the following page.</li><li>• Drop off your completed application at Member Services at any Kaiser Permanente medical center.</li></ul>

**Important:** When applying online by mail or fax, or dropping off your application in person, please be sure to fill out the application as much as you can. Any missing information may delay the application process.

### What to expect after you apply

After we review your completed application, we'll let you know one of the following outcomes within thirty (30) days of receipt:

- If your application is approved, you'll receive a letter notifying you of your financial award.
- If your application is incomplete, you'll receive a letter explaining the information needed to process your application. You can either mail or in-person drop off the requested information; this could include proof of income or copies of your out-of-pocket expenses.
- If your application is denied, you'll receive a letter notifying you why it was denied, in which case you can appeal our decision.

### Need help?

If you have any questions or need help with your application or need to check the status of your application, please call **1-844-412-0919 (TTY 711)**, Monday through Friday 9:30 a.m. to 3:30 p.m., EST. You can also talk to a Member Services representative at any Kaiser Permanente location.

## Medical Financial Assistance (MFA) Program application

Name: \_\_\_\_\_ Medical record #: \_\_\_\_\_

Date of birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Contact #: (\_\_\_\_) \_\_\_\_\_ SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP code: \_\_\_\_\_

**Household size:** Number of family members (including you) who live in your home. May include a spouse or qualified domestic partner, children, a non-parent caretaker relative, etc.

**Household income (monthly):** Total gross income for all family members in the household. Check ALL income types that apply:

- |                                                                      |                                                                                            |
|----------------------------------------------------------------------|--------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Employment Income/Wages                     | <input type="checkbox"/> Alimony/Child Support                                             |
| <input type="checkbox"/> Business Income/Rental Property             | <input type="checkbox"/> Pension or Retirement/Annuities                                   |
| <input type="checkbox"/> Unemployment Benefits/<br>Disability Income | <input type="checkbox"/> Social Security/Supplemental<br>Security Income/Veterans Benefits |

**Health care costs:** Total out-of-pocket expenses you had over a 12-month period for emergency or medically necessary services provided by Kaiser Permanente or any other health care provider. May include copays, deposits, coinsurance, or deductible payments for eligible medical, pharmacy, or dental services.

**Please list all members of your household applying for the program.**

Name	Date of birth	Relationship	Medical record #
_____	____/____/____	_____	_____
_____	____/____/____	_____	_____
_____	____/____/____	_____	_____
_____	____/____/____	_____	_____
_____	____/____/____	_____	_____

**Uninsured? Kaiser Permanente can help.** If you do not have health care coverage, we can help you understand your options. Check this box if you would like Kaiser Permanente to contact you to discuss your options or you can call us at **1-800-479-5764 (TTY 711)** to obtain a quote.

 Yes, contact me

I hereby declare that all information set forth above in this application is true, accurate, and complete in all respects. I also acknowledge and agree that I am liable to Kaiser Foundation Health Plan and Hospitals for all amounts owing to Kaiser Foundation Health Plan and Hospitals for medical goods and services that are not eligible under the Program (the "Remaining Amounts").

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Note:** Kaiser Foundation Health Plan and Hospitals reserves the right to use information from consumer credit reporting agencies and other third-party information sources to determine eligibility for federal, state, and private medical programs, including the MFA Program.