Medical Financial Assistance and Pharmacy Waiver Program

Medical financial assistance questions: **301-816-6615**

KAISER PERMANENTE®

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
2101 East Jefferson Street
Rockville, MD 20852

131719_MedFinAsst_M_br 4/4/14 –12/31/14

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Kaiser Permanente's Medical Financial Assistance (MFA) and Pharmacy Waiver program

If you need help paying for your Kaiser Permanente medical services, you may be eligible for the Kaiser Permanente MFA program, which includes our Pharmacy Waiver program.

The MFA program is a discretionary program subject to the limits of available funding and Kaiser Permanente's prioritization of need.

MFA is a voluntary program. If you are a Kaiser Permanente member, participation in this program will not affect your membership with Kaiser Permanente. Your financial information will be maintained according to privacy guidelines. Financial information collected will not be used for any other purpose by Kaiser Permanente nor will the information be shared with any other entity not directly associated with determining eligibility.

We offer medical financial assistance to patients that meet one of the following MFA eligibility guidelines:

- Your gross household income must be at or below 350% of the Federal Poverty Guidelines (FPG).
- You have unusually high medical costs or you've experienced a catastrophic event as defined by our policies.

If you have questions about the MFA program or the MFA application, please contact the Medical Financial Assistance Program at 301-816-6615, Monday–Friday, 8:30 a.m.–4:30 p.m.

Required documents

IMPORTANT: To avoid a delay in processing your application, please provide us with the following documents for all applicants:

- A signed copy of federal tax forms. If you do not pay taxes, please send a signed and dated statement that you did not file federal taxes.
- Complete copies of three current bank statements per account. This includes all checking and savings accounts.
- Copies of three current pay stubs.
- Copies of statements from income-generating retirement or other inventment accounts. Examples include award letters from:
  - Disability
  - Social Security
  - Unemployement
  - Retirement accounts
- **DO NOT SEND ORIGINALS of these supporting documents**. Please send photocopies only. If originals are sent, **THEY WILL NOT BE RETURNED**.

When you have completed your MFA application, please send it to:

Kaiser Permanente
Medical Financial
Assistance Department
2101 East Jefferson Street
Rockville, MD 20852-9468
Fax: 301-388-1746

Applicant's name: _____ Medical record number: _____

Phone number: _____

Spouse: _____ Spouse's medical record number: _____

List of family members applying for MFA: _____

_____

List of all additional family members in household: _____

_____

Employment status: Currently employed? ☐ Yes ☐ No _____Do you have a disability? ☐ Yes ☐ No

Do you own any rental property? ☐ Yes ☐ No

Have you applied for Medicaid? ☐ Yes ☐ No

Medicaid number: _____

Applicant/Guardian

_____
Last name, first name, middle initial

_____
Social Security number Date of birth

_____
Current street address Apt. number

_____
City State ZIP

Monthly gross income

Salary/wages	$ _____
Alimony/child support	$ _____
Business income	$ _____
Pension/Annuities	$ _____
Social Security/SSI/disability	$ _____
Rental property	$ _____
Other_____	$ _____

Current assets

_____ Checking account(s)	$ _____ Balance
_____ Savings account(s)	$ _____ Balance

Applicant's spouse

_____
Last name, first name, middle initial

_____
Social Security number Date of birth

_____
Current street address Apt. number

_____
City State ZIP

Monthly gross income

Salary/wages	$ _____
Alimony/child support	$ _____
Business income	$ _____
Pension/Annuities	$ _____
Social Security/SSI/disability	$ _____
Rental property	$ _____
Other_____	$ _____

Current assets

_____ Checking account(s)	$ _____ Balance
_____ Savings account(s)	$ _____ Balance

Monthly expenses	Monthly payment
Mortgage/rent	$
Property tax	$
Auto loans	$
Car insurance	$
Medical insurance premiums	$
Medication costs	$
Alimony/child support	$
Credit cards	$
Other monthly expenses (examples: food, utilities, gas, phone)	$
Other	$
TOTAL MONTHLY OBLIGATIONS	$

Financial agreement and credit report authorization

I hereby declare under penalty of perjury that all information set forth above in this application is true and accurate in all respects, and that all attachments are accurate copies of the original documents. I also acknowledge and agree that I am liable to Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. (KFHP), for any and all amounts owed to KFHP for medical goods and services that are not covered by the program. Applicant/guarantor will be notified by mail, whether application is approved or denied.

Signature of applicant/guardian Date

Signature of applicant's spouse Date

INCOMPLETE INFORMATION WILL RESULT IN A DELAY IN PROCESSING YOUR MFA APPLICATION.