GEORGIA REGION
MEDICAL FINANCIAL ASSISTANCE PROGRAM APPLICATION

Kaiser Foundation Health Plan of Georgia, Inc.
Nine Piedmont Center
3495 Piedmont Road, NE
Atlanta, Georgia 30305-1736

For help or questions about the Medical Financial Assistance application process, please call 1-404-949-5112, or speak to a Business Office Supervisor within the Patient Business Office.

1. PATIENT INFORMATION

Date		Interviewed By	
Patient's Name (last)		(first)	(middle initial)
Address			Apt. #
City		State	ZIP Code
Date of Birth		Health Record #	
Home Phone #	Work Phone #	Cell/Mobile Phone #	
Patient's Employer			
Employer's Address	City	State	Zip Code

2. SPOUSE INFORMATION

Spouse's Name (last)		(first)		(middle initial)
Address	Apt. #	City	State	ZIP Code
Home Phone #	Work Phone #		Cell/Mobile Phone #	
Spouse's Employer		Length of Employment		
Employer's Address		City	State	Zip Code

3. DEPENDENT(S)

Name	Date of Birth	Relationship
Name	Date of Birth	Relationship
Name	Date of Birth	Relationship

4. FAMILY HOUSEHOLD INCOME

Total Gross Income $

Income Source	Income Amount $
Income Source	Income Amount $
Income Source	Income Amount $
Income Source	Income Amount $

Remarks

Treating Physician or Clinician

Supplies or Services Requested

Change in Circumstances What change has happened to you or your family to leave you in this need?

5. OTHER DOCUMENTS

The following documents must accompany your application at the time of your interview.

- 3 Community resource contacts (i.e. Supplemental Nutrition Assistance Program, utility assistance, church assistance, etc)
  - – Name of Institution
  - – Telephone number
  - – Name of individual contacted
  - – Date
  - – Outcome
- Last 2 most recent pay stubs and/or disability stubs (maybe provided in lieu of W2/Tax Returns)
- Most recent W-2/Tax Return
- Entire 2 months Checking account statement to include most current
- Entire 2 months Savings account statement to include most current
- Any Income Award Letter (i.e. Social Security, Disability, Unemployment)
- Child Support
- Other miscellaneous income

Please attach W-2 forms for previous year and pay stubs for the entire family household or other verification of income. Patients are eligible for Financial Assistance when their Family Household Income is at or below 400% of the Federal Poverty Guidelines (FPG). Evaluation of other criteria may be required.

Kaiser Permanente will protect the confidentiality of the information you provide and will only use the information provided for the purposes described below.

I certify that the information on this form is correct. Upon request, I will furnish Kaiser Permanente any necessary documentation to confirm this information. This documentation may include proof of income, proof of assets, or both.

I consent to Kaiser Permanente Health Plan of Georgia, Inc. obtaining information from consumer credit reporting agencies and other third party information sources for the purpose of determining eligibility for state, federal, and private medical programs.

I further understand that there are circumstances, such as billing account review and/or collections, for which Kaiser Foundation Health Plan of Georgia, Inc. does not need a patient's consent to perform a credit inquiry.

I have read, understand, and fully agree to each provision in this form, and sign below as my free and voluntary act. In addition, I have received a copy of this form.

Signature (applicant or applicant's personal representative)	Date
Signature (witness)	Date

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