Kaiser Permanente Community
Health Coverage Program - California

Instructions for completing the Community Health Coverage Program (CHCP) Application for Subsidy Form

This document tells you how to complete the Community Health Coverage Program (CHCP) Application for Subsidy Form when applying for the Kaiser Permanente Community Health Coverage Program in California.

What you need to do:

- **Complete the form**, including proof of income and other required documents if applicable.
- **Sign and date** the application on page 11.
- **Make a copy** of your completed form for your records.
- **Send your documents** in one of these ways:

By email: CHC-Applications@kp.org

- Include the word "application" in the subject line.

By mail: Kaiser Permanente
Attn: CHC
P.O. Box 939095
San Diego, CA 92193-9095

By fax: 1-855-355-5334

- Be sure to save the fax confirmation page.

You can also apply online!

- Go to kp.org/chcp/apply and click the link.

We're here to help

If you have any questions, please call Member Services at **1-800-464-4000** (TTY **711**), 24 hours a day, 7 days a week (closed major holidays).

You can contact a participating community partner with questions. Visit **kp.org/chcp/gethelp** to find a community partner nearest to you.

KAISER PERMANENTE®

Community Health Coverage Program (CHCP) Application for subsidy – 2026

Use this form to apply for a subsidy to pay your monthly premiums and most out-of-pocket costs under the Kaiser Permanente - Platinum 90 HMO plan. There is no cost to apply.

Enrollment in CHCP is available during the Individuals and Families annual open enrollment and special enrollment periods. The special enrollment period generally lasts 60 calendar days from the date of your qualifying life event. Some qualifying life events allow more than 60 calendar days from the date of your qualifying life event. Visit **kp.org/chcspecialenrollment** for more information. To apply, follow these steps:

Step 1: Fill out the Application for subsidy form

- Type or print using black or blue ink.
- Answer all required questions completely.
- Sign the form.
- Make a copy of the completed form for your records.

Step 2: Fill out 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 1040 tax form from previous year. Please note: if tax form is submitted, no other proof of income is required.
- 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 indicating gross income and pay frequency from your employer.
- See Section 4 for more examples of proof of income.

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

- Student loan interest – include your last student loan statement.
- Self-employed – Schedule C and page 1 (the adjusted gross income page) of last year's federal income tax return or a profit and loss form.

Eligibility

Eligibility for CHCP will be considered for individuals who are uninsured and:

- Live in the Kaiser Foundation Health Plan, Inc. California service area.
- Live in a household with an income up to 300% of the federal poverty level.
- Not eligible for other public or private healt such as, but no Medi-Cal, Med affordable job Covered Calif
- In most cases, child dependents must be younger than 26.
- Individuals over 21 are eligible to receive the CHCP subsidy for a maximum of 3 years in a row. Eligible dependents can continue to receive the subsidy until they turn 21, no matter how long they've been in the program.
- The CHCP subsidy is available as a one-time resource, and all members must reapply annually. Members who do not reapply in consecutive years will lose future eligibility.

Reminder: Make sure the 2026 version of the form is being used

Be sure to make a copy of the application form for your records

Step 4: Include additional documents

- Medi-Cal and/or Covered California denial letters if applicable.
- Provide proof of guardianship if applicable.
- Other information or documentation that may help us evaluate your eligibility.

Step 5: Send your forms, proof of income, and all other required documents

Send your completed and signed Application for subsidy, Application for health coverage, proof of current income, income deductions, and other required documents through one of the following options:

- By email (preferred):
  CHC-Applications@kp.org
  (Include "application" in the subject line)
- By mail:
  Kaiser Permanente
  Attn: CHC
  P.O. Box 939095
  San Diego, CA 92193-9095
- By fax:
  1-855-355-5334

We're here to help:

If you have questions about the Kaiser Permanente Community Health Coverage Program (CHCP) or about this form, pleas
1-800
24 ho
(close

Email is highly encouraged and the preferred method for submission. Please ensure you include the word "**application**" in the subject line when emailing your application and supporting documents.

Please note: Continued eligibility for CHCP isn't guaranteed. We reserve the right to close enrollment or change the eligibility rules at any time. If you're approved for the subsidy, the subsidy period is limited and we'll contact you in the future to confirm that you still qualify.

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 other purposes required by law.

Frequently asked questions

1. **How long does it take to find out if I am approved or denied [illegible]manente Commu[illegible] Health Coverage Program (CHCP)?**
   Completed forms that include all required documentation can take up to 6 weeks t[illegible] information is missing, it may take longer and you may miss the deadline for applying. Completi[illegible] this form does not guarantee enrollment in CHCP.

2. **How much will I pay each month for CHCP?**
   No monthly payment is required. Kaiser Permanente will subsidize the full monthly premium.

3. **What happens when I no longer meet the eligibility requirements?**
   When you no longer meet our eligibility requirements, you will be disenrolled from CHCP. You wi[illegible] remain enrolled in the Kaiser Permanente - Platinum 90 HMO plan, **but you'll have to pay your full monthly premiums and out-of-pocket costs,** unless you ask us to end your membership or until you fail to pay the full premium.

4. **I can't afford to pay for coverage through Covered California. Can I still qualify for CHCP?**
   Not being able to pay Covered California premiums does not qualify you for CHCP. You must meet the CHCP income and other criteria to qualify.

5. **Do I qualify for CHCP if I am offered health coverage through an employer?**
   To be eligible for CHCP, applicants must not have access to an employer plan that is considered affordable. CHCP follows federal guidelines for affordability. For 2025, the threshold that determines if an employer plan is affordable is if the premium is equal to or less than 9.02% of one's household income. If you believe your job-based coverage is unaffordable, please submit proof of job-based coverage and include information on the cost of coverage and frequency of payment.

6. **What other health coverage programs are available?**
   Find out if you qualify for Medi-Cal. This option may be available if you meet the following eligibility requirements:

   - Children younger than 19 living in households with income at or below 266% of the Federal Poverty Level (FPL) ($41,629 for an individual or $85,519 for a family of 4 in 2025).
   - Adults 19-64 with household income up to 138% of the FPL ($21,597 for an individual or $44,367 for a family of 4 in 2025). Beginning 1/1/2026, adults 19 and older must have an eligible citizenship or immigration status to qualify. Kaiser Permanente is a Medi-Cal provider and may be available to you.
   - Pregnant individuals with income up to 213% of the FPL ($33,335 for an individual or $68,480 for a family of 4 in 2025).
   - For more information, please visit **kp.org/medi-cal** or call the Kaiser Permanente Medicaid Assistance Center at **1-800-557-4515** (TTY **711**). You may also contact a community organization or your local county services office for more information.

   Buy health care coverage through Covered California. If you qualify, you may get help paying for your plan premiums or out-of-pocket costs. Remember to enroll during the Covered California open enrollment period. If you wait until after the open enrollment period ends, you'll need a qualifying life event to enroll in a new plan. For more information, visit CoveredCA.com, which also has Kaiser Permanente plans.

   Call us at 1-800-488-3590 (TTY 711) or visit buykp.org to learn about other Kaiser Permanente for Individuals and Families plan choices.

   Find out if you qualify for Medicare, a federal program available to people ages 65 or older. There are different periods in which you may be eligible to enroll in a Medicare health plan. Visit **kp.org/medicare** for more information. If you have limited household income, you may qualify for Medi-Cal. Please visit **kp.org/medi-cal** to learn more.

7. **What if I'm not accepted into CHCP?**
   If you're not accepted, there may be other health coverage programs available to you. See question 6 for more information.

Be sure to review the "Frequently asked questions" before completing the subsidy eligibility form

SECTION 1: Applicant information (Required)

Primary applicant

The person who will be covered by
Community Health Coverage Progr
complete section 1 with the child's
or legal guardian information.

First name*

Last name*

Date of birth* (mm/dd/yyyy)

Medical record number (if available)

Gender* ☐ Male ☐ Female ☐ Undeclared

Home phone

Mobile phone

Home address* (Include Apt. Number. No P. O. boxes, please)

City*

State*

ZIP code*

Mailing address (If different than home address. Include apt. number.)

City

Email

Please answer **ALL** applicable questions below about the primary applicant. This information is only used to find out if the primary applicant is eligible for CHCP or other programs that provide health coverage.

Is the primary applicant…

Offered health coverage thro h an employer?* ☐ Yes ☐ No

Not eligible for (or has received nial of coverage from) public health programs or other subsidized insurance options?* (fo ple: M

*Indicates a required field

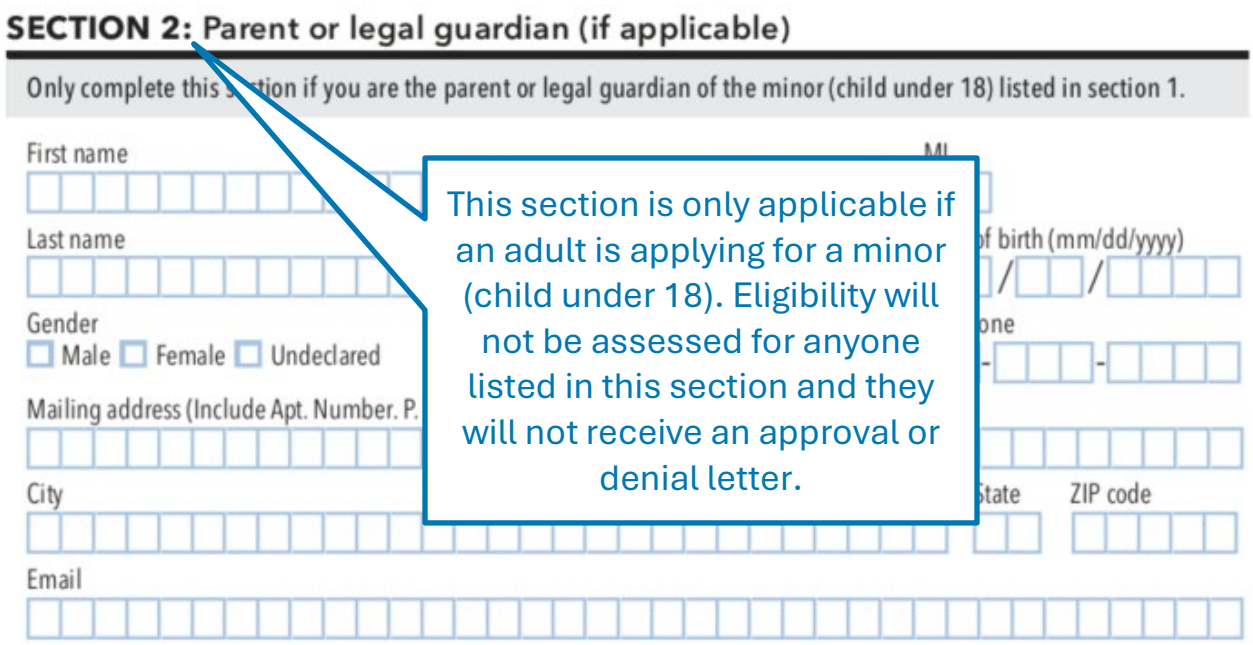
This is only applicable to applicants who are prior Kaiser Permanente members. You can find your Medical Record Number or Health Record Number on the member ID card or through kp.org.

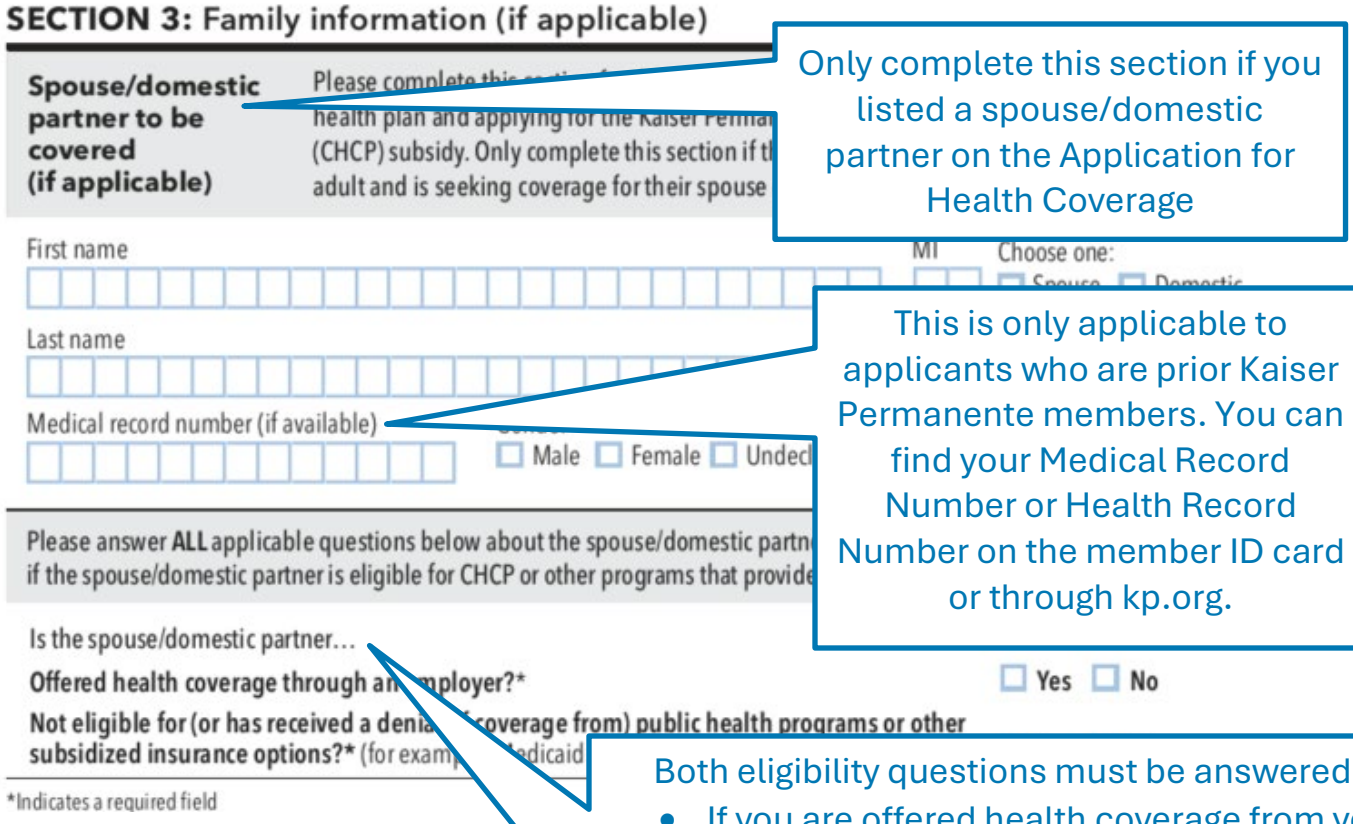
Reminder: Include Apt # or Suite # and validate address with applicant

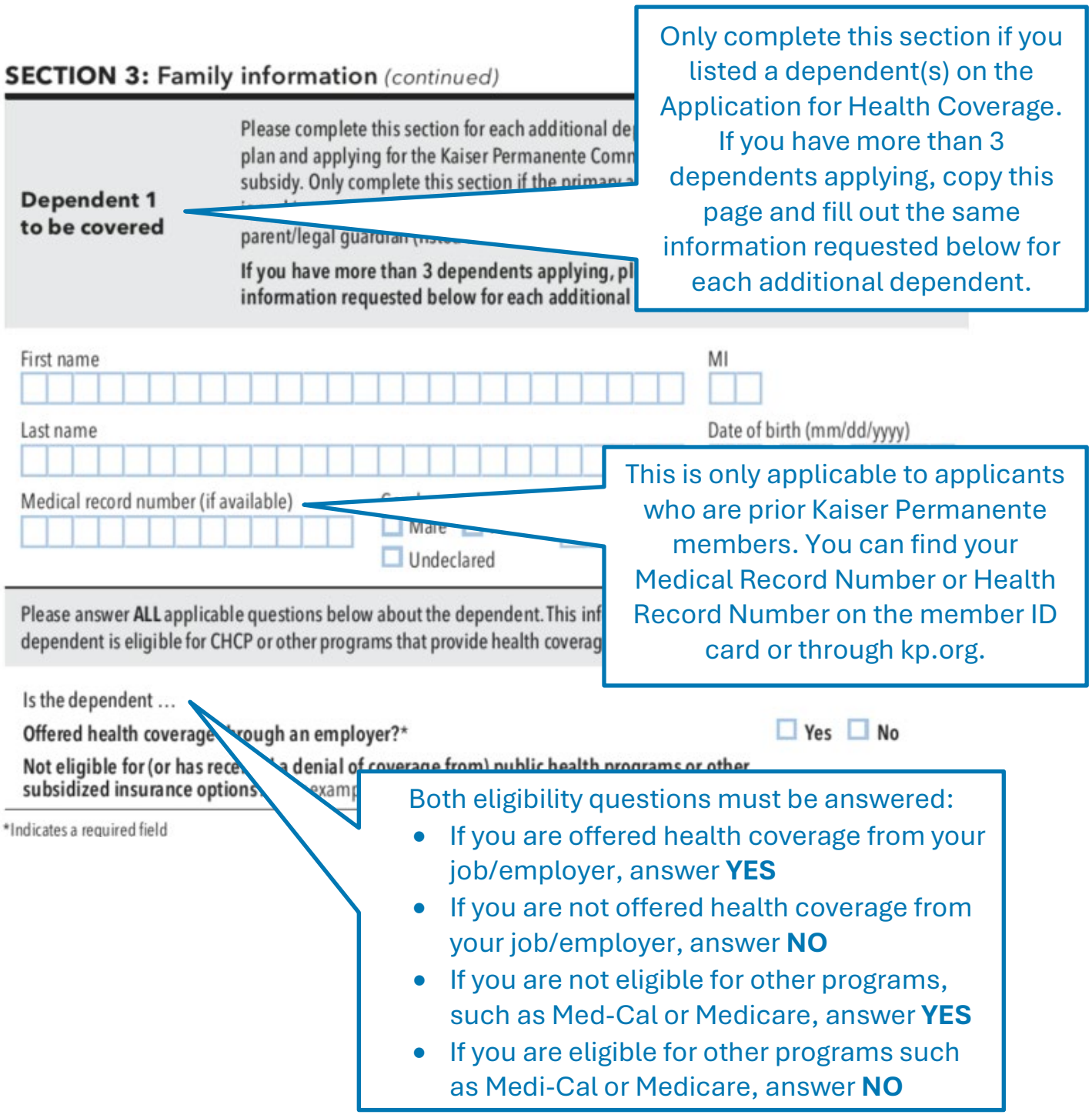
Providing a phone number and email address is HIGHLY encouraged in case the application processing team has questions about the form

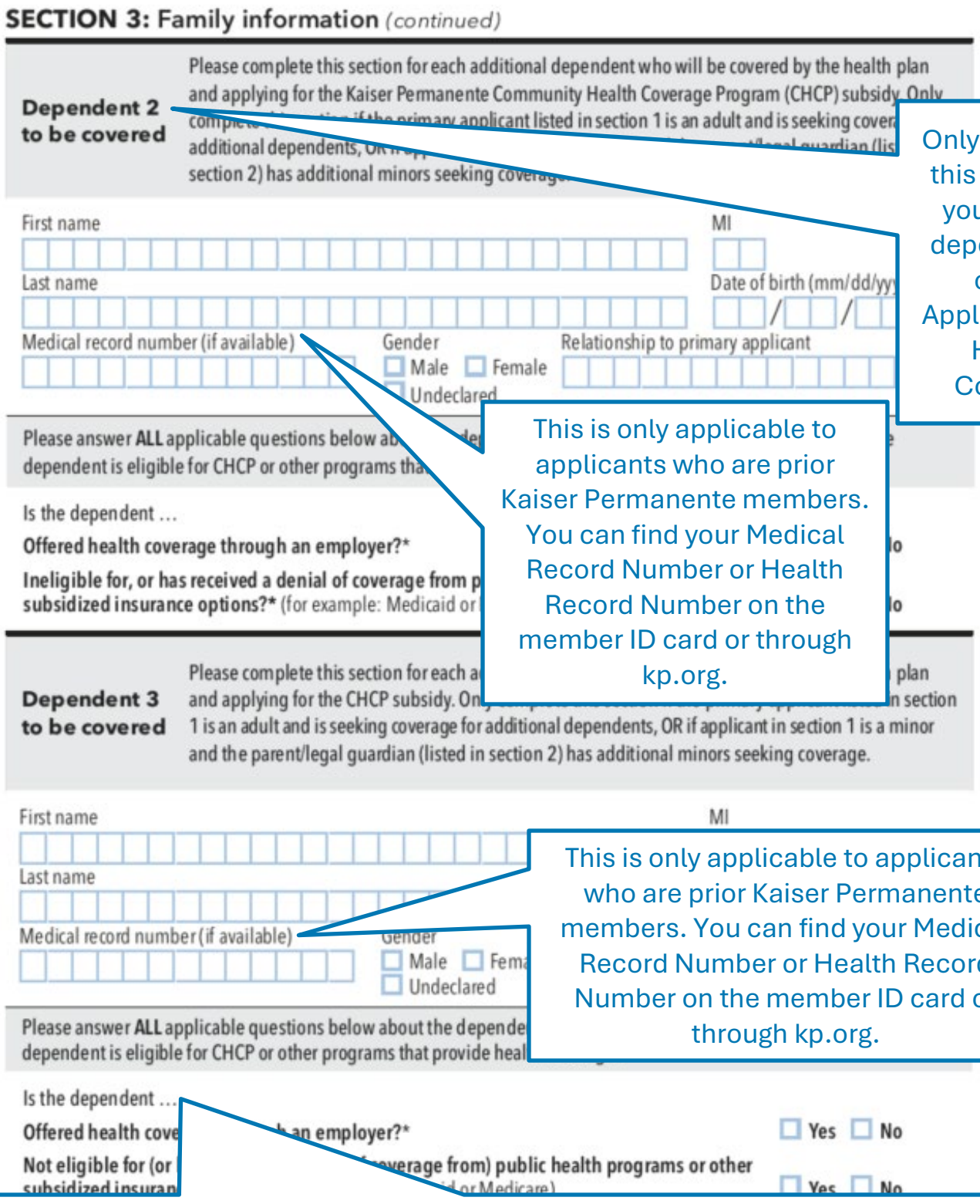
Both eligibility questions must be answered:

- If you are offered health coverage from your job/employer, answer **YES**
- If you are not offered health coverage from your job/employer, answer **NO**
- If you are not eligible for other programs, such as Med-Cal or Medicare, answer **YES**
- If you are eligible for other programs such as Medi-Cal or Medicare, answer **NO**


SECTION 2: Parent or legal guardian (if applicable)
Only complete this section if you are the parent or legal guardian of the minor (child under 18) listed in section 1.
First name
MI
Last name
of birth (mm/dd/yyyy)
Gender
Male
Female
Undeclared
one
Mailing address (Include Apt. Number. P.
City
State
ZIP code
Email
This section is only applicable if an adult is applying for a minor (child under 18). Eligibility will not be assessed for anyone listed in this section and they will not receive an approval or denial letter.


SECTION 3: Family information (if applicable)
Spouse/domestic partner to be covered (if applicable)
Please complete this
health plan and applying for the Kaiser Perma
(CHCP) subsidy. Only complete this section if t
adult and is seeking coverage for their spouse
First name
MI
Choose one:
Last name
Medical record number (if available)
Male
Female
Undecl
Please answer ALL applicable questions below about the spouse/domestic partn
if the spouse/domestic partner is eligible for CHCP or other programs that provide
Is the spouse/domestic partner...
Offered health coverage through an
mployer?*
Yes
No
Not eligible for (or has received a denia
coverage from) public health programs or other
subsidized insurance options?* (for exam
edicaid
*Indicates a required field
Only complete this section if you listed a spouse/domestic partner on the Application for Health Coverage
This is only applicable to applicants who are prior Kaiser Permanente members. You can find your Medical Record Number or Health Record Number on the member ID card or through kp.org.
Both eligibility questions must be answered:
• If you are offered health coverage from your job/employer, answer YES
• If you are not offered health coverage from your job/employer, answer NO
• If you are not eligible for other programs, such as Med-Cal or Medicare, answer YES
• If you are eligible for other programs such as Medi-Cal or Medicare, answer NO


SECTION 3: Family information (continued)
Please complete this section for each additional de
plan and applying for the Kaiser Permanente Comm
subsidy. Only complete this section if the primary a
Dependent 1 to be covered
parent/legal guardian (
If you have more than 3 dependents applying, pl
information requested below for each additional
First name
MI
Last name
Date of birth (mm/dd/yyyy)
Medical record number (if available)
Male
Undeclared
Please answer ALL applicable questions below about the dependent. This inf
dependent is eligible for CHCP or other programs that provide health coverag
Is the dependent …
Offered health coverage through an employer?*
Yes
No
Not eligible for (or has rece a denial of coverage from) public health programs or other
subsidized insurance options examp
*Indicates a required field
Only complete this section if you listed a dependent(s) on the Application for Health Coverage. If you have more than 3 dependents applying, copy this page and fill out the same information requested below for each additional dependent.
This is only applicable to applicants who are prior Kaiser Permanente members. You can find your Medical Record Number or Health Record Number on the member ID card or through kp.org.
Both eligibility questions must be answered:
• If you are offered health coverage from your job/employer, answer YES
• If you are not offered health coverage from your job/employer, answer NO
• If you are not eligible for other programs, such as Med-Cal or Medicare, answer YES
• If you are eligible for other programs such as Medi-Cal or Medicare, answer NO



Only complete this section if you listed a dependent(s) on the Application for Health Coverage

This is only applicable to applicants who are prior Kaiser Permanente members. You can find your Medical Record Number or Health Record Number on the member ID card or through kp.org.

This is only applicable to applicants who are prior Kaiser Permanente members. You can find your Medical Record Number or Health Record Number on the member ID card or through kp.org.

Both eligibility questions must be answered:

- If you are offered health coverage from your job/employer, answer **YES**
- If you are not offered health coverage from your job/employer, answer **NO**
- If you are not eligible for other programs, such as Med-Cal or Medicare, answer **YES**
- If you are eligible for other programs such as Medi-Cal or Medicare, answer **NO**

SECTION 4: Household income (Required)

Your family size, household income, and proof of income documents help us determine
yearly household income, we'll add up the amounts shown in your proof of income

w many family members† live in your household?* _____

file taxes, this is the same number of family members that you report on your tax form. (You do not need to file taxes to) This usually includes you and the immediate family members who live with you. Like your spouse and your children 18 unger (up to 23 if a student).

many of the family members counted in question (A) above contribute to your household income?* _____

lude working child dependents (18 and younger, or up to 23 if a student) whose income is below the tax-filing threshold (in 2025). Don't submit proof of income documents for them either.

☐ I do not work / No one in my household works. (if this is selected, skip sections C & D)

ovide proof of your household income.

your household DOES NOT have proof of income (for example: a paystub or W-2), check the box below and fill the blank with monthly household income.

☐ I attest that I have no proof of income. My MONTHLY household gross income is $_____ per month.

you have income that varies by month, such as tips, overtime, or commissions, check the box below and fill in the blank with the estimated total gross income in 2025.

☐ I attest that I have income that varies by month. My total expected gross income in 2025 is $_____
Include the total amount received so far this year and estimate the expected amount for the rest of the year.

If your household has proof of income, please submit documentation for the income you receive. Attach copies of the most current proof of income for EVERY family member that contributes to household i me.

Qualifying income and relevant examples are listed below:

Wages and/or tips:	Your last 2 paycheck stubs, W-2 from e rm. Note: if tax form is submitted, no other proof of i
Self-employment:	A profit and loss form, or schedule C a ome tax return (the adjusted gross income page)
Social security payments:	Award letters for social security and S SSDI) payments
Unemployment benefits	Award letters for unemployment bene
Alimony received	Submit court documents or a letter f payment information.(only if your divorce or se uary 1, 2019)
Student financial aid used for living expenses (Student loans and financial aid for tuition/education expenses are n	
Pension/retirement income	
Rental income from property you own and lease	
Interest or investment income and annuities	
Other income like capital gains, clergy earnings, or gambling inc	

Please explain any special situation that we should consider when we are reviewing your income documents. (if applicable) _____

(D) Attach copies of the most current proof of tax deductions for EVERY family member that contributes to household income. (if applicable)

Reminder: Only include family members that are or would be included on your tax form

This question MUST be answered, even if it is "0"

Only check this box if the primary applicant and no one in the household currently works

Complete this section if you DO NOT have proof of income. Please provide your **MONTHLY** gross income amount.

Complete this section if you have income that varies. Please provide the total **ANNUAL** expected gross income amount for 2025.

SECTION 4: Household income (Required)

Qualifying Deductions:

- **Self-employed expenses:** Only if submitting a profit and loss form. If submit[ting] schedule C of last year's federal income tax return, we will review the adjusted gross income on page 1.
- **Alimony you pay:** Submit court documents or a letter from your former spouse detail[ing] your divorce or separation was finalized before January 1, 2019)
- **Interest you pay on a student loan:** Submit your 1098-E Student Loan Interest form from th[e]
- **IRA contributions:** Submit your Form 5498 from the most recent tax year. (if you don't have through a job)
- **Teacher expenses** (if you're a teacher and pay for supplies out-of-pocket)
- **Health Savings Account (HSA) deposits:** Submit your completed Form 8889. (in limited situations)

If you have qualifying deductions, please provide documentation

SECTION 5: Community Partner Verification

Organization name

Organization phone

Phone extension (if applic[able])

Organization email address

Community partner representative

I attest that I assisted the applicant(s) with this application for the Kaiser Permanente Community Health Coverage Program (CHCP). I understand and agree that I will commit to serving as a point of contact for Kaiser Permanente Membership Administration regarding follow up or questions related to this application.

X

Date (mm/dd/yyyy)

Signature of community partner representative

(continues)

If a community partner assists with the application form, please complete this section

The community partner representative's signature is required

SECTION 6: 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 on matters related to this form only. This person or community partner/agency is called an authorized representative.

First name

Last name

Organization name (if applicable)

Phone

By signing, you've appointed this person or community pa... to get information for this Kaiser Permanente form and to act for you on matters related to this form.

X

Date (mm/dd/yyyy)

Primary applicant (parent or legal guardian for children...

This authorization lasts until December 31, 2027 or until you cancel... time by submitting a signed written request to Kaiser Permanente... 92193-9095 or fax: 1-855-355-5334. Once you cancel, we will sto... it, except to the extent that the information has been relied upon before. Once we disclose to your representative, your information may be redisclosed by your representative and no longer protected by federal privacy law. Even if you don't sign this authorization, we will still process your application for the Kaiser Permanente Community Health Coverage Program (CHCP) subsidy but we will not be able to share your information with your representative. You have a right to receive a copy of this authorization.

X

Date (mm/dd/yyyy)

Primary applicant (parent or legal guardian for children under...

SECTION 7: Sign the application agreement (Re...

By signing this form, you certify the information on this form is correct and ... 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. Kaiser Permanente reserves the right to request additional documentation at any time to verify our member's eligibility. Membership approval for Kaiser Permanente's Community Health Coverage Program (CHCP) is not guaranteed as it is based on eligibility and availability.

X

Date (mm/dd/yyyy)

Primary applicant (parent or legal guardian ... under...

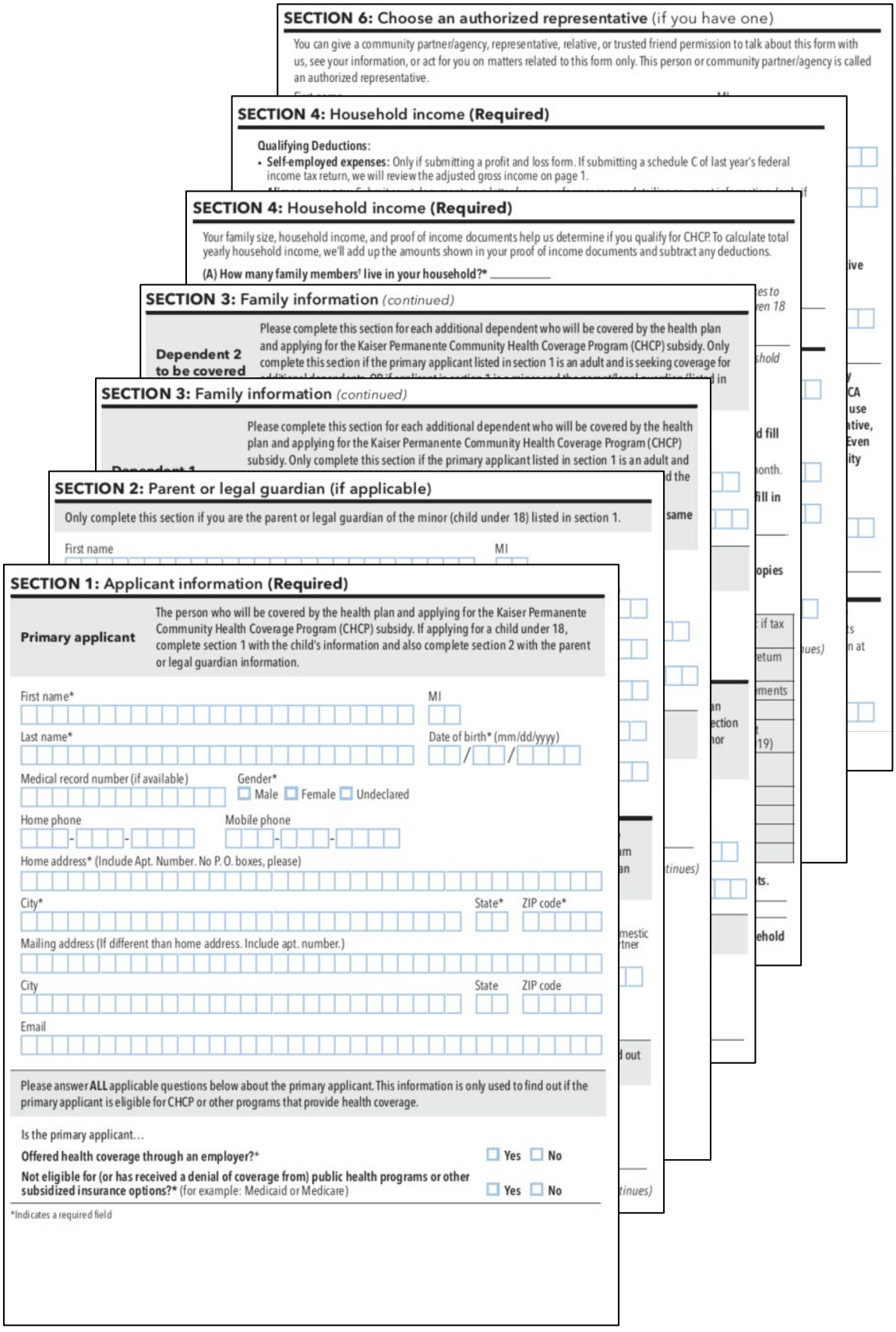
All plans are offered and underwritten by Kaiser Foundation ... d, CA 94612.

An Authorized Representative is only for the purpose of assisting with this form. If you'd like to have your community partner be your authorized representative to assist you if there are any questions about the application form, they must be listed here in addition to Section 6.

The primary applicant is required to sign if an authorized representative is provided

The primary applicant is required to sign if an authorized representative is provided

The primary applicant's signature is required



Send your documents in one of these ways:

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CHC-Applications@kp.org

Mail
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P.O. Box 939095
San Diego, CA 92193-9095

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