KAISER PERMANENTE

**Member Services Department return to:**
**Kaiser Foundation Health Plan, Inc.**
**P.O. Box 23219**
**San Diego, California 92193-3219**
**Or fax to: (858) 614-3344**

# Disabled Dependent Enrollment Application

**To the Subscriber:** Please provide the following information about the applicant for whom you are seeking enrollment or re-certification by Kaiser Foundation Health Plan, Inc. (KFHP) for disabled dependent health care coverage. Please complete all of Part A, (Sections 1 - 4). Your Physician must complete part B. Once all sections of the application have been completed with all supporting documentation attached (all supporting documentation must be reflective of the 12-month period prior to the date of this application) mail or fax the application to the address/fax number at the top of page 1. If the applicant qualifies, disabled dependent coverage will be made effective the first of the month following the date of our determination.

## PART A

### Section I – Applicant Information

| APPLICANT'S LAST NAME (PLEASE PRINT) | FIRST NAME | MIDDLE INITIAL | KP MEDICAL RECORD # |
|---|---|---|---|
| ADDRESS | | TELEPHONE # | |
| CITY | STATE | ZIP CODE | |
| APPLICANT'S SOCIAL SECURITY # | APPLICANT'S BIRTHDATE (Mo., Day, Year) | APPLICANT'S RELATIONSHIP TO KFHP SUBSCRIBER / SUBSCRIBER'S SPOUSE | |

### Section II – Subscriber Information

| SUBSCRIBER'S LAST NAME | FIRST NAME | MIDDLE INITIAL | KP MEDICAL RECORD # |
|---|---|---|---|
| ADDRESS | | TELEPHONE # | |
| CITY | STATE | ZIP CODE | |
| SOCIAL SECURITY # | GROUP # | FAMILY ACCOUNT # | |
| SUBSCRIBER'S EMPLOYER | EMPLOYER ADDRESS | EMPLOYER TELEPHONE # | |

### Section III – Physician Information

Please designate the applicant's Kaiser Permanente physician or outside physician.

| PHYSICIAN'S NAME | KFHP Facility or Physician Location/address | OFFICE TELEPHONE NUMBER |
|---|---|---|
| | | |

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**Part A – Section IV – Subscriber Questionnaire**

| Circle One | | *Please Read each of the following Statements carefully. Indicate a "Yes" or "No" response to the statements below. You must provide all information requested in order for your application to be processed. If you need more space, attach a separate sheet of paper.* |
|---|---|---|
| **Yes** | **No** | **1.** Is the applicant currently enrolled as a dependent on our account? If No, has the applicant been enrolled as a dependent on your KFHP plan within the past 12 months prior to the date of this application? **Please explain:** _____ _____ _____ |
| **Yes** | **No** | ***2.*** Is the applicant dependent upon you or your spouse for his or her support and maintenance? (Support and maintenance of the applicant is defined as customary living expenses such as housing, transportation, food, medical care, clothing etc. that you or your spouse provides.) ***If yes, you must complete the following for the dependent's average monthly living expenses reflective of the past 12 months prior to the date of this application.*** |

| Dependent average monthly expense | Expense Type | *Other expense type explanation |
|---|---|---|
| **$** | **Housing/Rent** | |
| **$** | **Transportation** | |
| **$** | **Food/Toiletries** | |
| **$** | **Medical Care** | |
| **$** | **Clothing** | |
| **$** | ***Other** | |
| **$** | ***Other** | |
| Total Monthly Expenses **$** | | |

| | | |
|---|---|---|
| **Yes** | **No** | **3.** Was the applicant claimed as a dependent on your or your spouse's most recent federal tax return? If yes, please provide a copy of the page of your most recent tax return, which lists your dependent(s). **If no, please explain why:**_____ _____ _____ _____ |
| **Yes** | **No** | **4**. Does the applicant qualify or receive any government-sponsored aid or income because of his or her disabled status? **If yes, please check all that apply**: |

| Type of Aid | Amount of Benefit | Benefit Start Date |
|---|---|---|
| ☐ Social Security Disability Insurance (SSD)? | | |
| ☐ Supplemental Security Income (SSI)? | | |
| ☐ Medi-Cal? | **N/A** | **N/A** |
| ☐ Medicare Part A (Hospital) | **N/A** | **N/A** |
| ☐ Medicare Part B (Medical Care) | **N/A** | **N/A** |
| **Other (Describe):** | | |

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# Disabled Dependent Enrollment Application

| Yes | No | |
|---|---|---|
| **Yes** | **No** | **5.** Has the applicant worked, including sheltered work, within the past 12 months, prior to the end date of the application? **If yes, please attach proof of the applicant's earnings for the past 12 months from the date of this application and provide the following information:**<br><br>Name and address of employer:<br><br>_____<br><br>_____<br><br>_____<br><br>Supervisors name and telephone number:<br>_____<br><br>_____ |
| **Yes** | **No** | **6.** Is the applicant currently living with you? **If yes, how long?** _____<br>**If No, please indicate where the applicant is residing**:<br>_____ |
| **Yes** | **No** | **7.** Has the applicant lived in a group home or other assisted living arrangement within the past 12 months prior to the date of the application? **If yes, please provide the following information:**<br><br>Name:_____<br>–<br>Address_____<br>–<br>Phone Number: |
| **Yes** | **No** | **8.** Has the applicant attended school within the past 12 months prior to the date of application? **If yes, specify the name of the school and the course of study:**<br>_____<br><br>_____ |

***I hereby certify that, to the best of my knowledge, the above information is complete and correct.***

| **Subscriber's Signature** | **Date:** |
|---|---|
| **X** | |

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**Disabled Dependent Enrollment Application**

## PART B

Section I – To be completed by Applicant's Physician: The following information is needed for use in connection with an application for continued health insurance coverage for a disabled dependent. Please provide your full reply and describe the nature and severity of the impairment. If part A has been completed in full and all supporting documentation is included you may mail or fax this application to the address and fax number at the top of Page 1.

**NOTICE TO PHYSICIAN:** PLEASE TYPE OR PRINT.

| APPLICANT'S LAST NAME, FIRST NAME | KP MEDICAL RECORD # |
|---|---|
| SUBSCRIBER'S LAST NAME, FIRST NAME | KP MEDICAL RECORD # |

**CLINICAL DESCRIPTION OF APPLICANT'S CONDITION, INCLUDING DIAGNOSIS AND PROGNOSIS CAUSING DISABILITY AND DESCRIPTON OF LIMITATIONS: (Must be completed by physician)**

(Use reverse side for additional comments or attach documentation.)

**PHYSICIAN COMMENTS: (Must be completed by physician)**

(Use reverse side for additional comments or attach documentation.)

**IN ADDITION TO THE INFORMATION REQUIRED ABOVE, PLEASE PROVIDE ANSWERS TO THE FOLLOWING QUESTIONS:**

1) DATE DISABILITY OCCURRED

2) IN YOUR MEDICAL OPINION, IS THE DISABLITY:

**MENTAL RETARDATION** _____Yes _____No **PHYSICAL HANDICAP** _____Yes _____No

**Biologically based Psychiatric Disorder** _____Yes _____No

3) IN YOUR MEDICAL OPINION, IS THE DISABLITY LIKELY TO IMPROVE?

_____ YES _____ NO

4) IN YOUR MEDICAL OPINION, DOES THE DISABILITY RENDER THE APPLICANT INCAPABLE OF SELF-SUSTAINING EMPLOYMENT?

_____ YES _____ NO

| ATTENDING PHYSICIAN'S SIGNATURE | DATE |
|---|---|

| PHYSICIAN'S PRINTED NAME | KFHP Facility or Physician's Mailing Address | |
|---|---|---|
| CITY | ZIP CODE | PHYSICIAN'S OFFICE TELEPHONE # |

# Statement of Authorized Representative

**PART A:** If you wish to give authority to another party to file an appeal on your behalf for enrollment on your parent's plan as a disabled dependent, please complete the following information. If you wish this person to receive Protected Health

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# Disabled Dependent Enrollment Application

Information (PHI) regarding your medical history and care, you must check the appropriate box(s) below and you and your representative must both sign and date this form. **Please return the completed form to Kaiser Foundation Health Plan California Service Center - Disabled Dependent Coordinator - P O Box 23219 - San Diego, CA 92193-3219 or fax to: (858) 614-3344.**

| | |
|---|---|
| Your Name & Address: | |
| Daytime Phone #: ( ) | Alternate Phone #: ( ) |
| Medical Record #: | Medicare # |

**PART B:** I hereby authorize the person named below to represent me my eligibility as a disabled dependent with Kaiser Permanente based on both my medical and financial status.
I understand that this authorization is voluntary and, if I choose to do so, I have the right to revoke it in writing to KFHP and to my designated representative. KFHP and my designated representative will no longer use or disclose my PHI, except to the extent KFHP or my designated representative has taken action in reliance upon this authorization.

| | | |
|---|---|---|
| Name of Designated Person: | | |
| Address: | | |
| City: | State: | Zip: |
| Daytime Phone #: ( ) | Evening Phone #: ( ) | |

- ☐ I authorize KFHP to disclose Protected Health Information regarding my medical condition and care and/or payment information to the above named individual. This information must be relevant to the request filed with Member Services on _____ (date of request).

  —The above authorization may include the following medical records and type of information, if box(es) are checked:

  - ☐ Psychiatric treatment
  - ☐ Drug/Alcohol or other chemical dependency treatment
  - ☐ HIV related treatment or testing

- ☐ This authorization shall become effective immediately and shall remain in effect until the earlier or final resolution of my request or _____ (specify date).

**Your Signature**: _____ **Date**: _____

**PART C:**

I am authorized to sign this authorization on behalf of _____ and on the basis of:

- ☐ Legal Authority (Power of Attorney, etc.)
- ☐ Written Designation by the Member
- ☐ Parent, Guardian or other individual acting in loco parentis

**Authorized Representative**: _____ **Date**: _____