



**KAISER PERMANENTE**

California Service Center  
Disabled Dependent Team  
P.O. Box 23219  
San Diego, California 92193-3219

05/26/2006

Subscriber's Name	Purchaser/Enrollment Unit:
Street Address	Purchaser Name:
City, State, Zip	Subscriber MRN:
	Dependent Name:
	Dependent MRN:

Dear Mr./Ms. \_\_\_\_\_,

We have received information indicating your interest to enroll your child at Kaiser Permanente as a Disabled Dependent. Please complete the enclosed application and submit to our department for processing. To ensure a thorough evaluation, please include the following items.

- A Kaiser Permanente Physician or an outside physician must complete part B.
- A list of your dependent's average monthly living expenses. Please see question #2.
- A completed and signed Statement of Authorized Representative, which allows us to share protected information regarding the adult dependent with the parent or subscriber of the account.
- A copy of the **first** page of your most recent tax return which lists your dependent(s). Please see question #3.

Please retain a copy for your records.

Please return the requested information in the enclosed envelope or fax to 1-858-614-3344.

If we do not hear from you or receive the information within 90 days from {date field}, we will presume you are no longer interested and cancel your application for membership.

Sincerely,

Disabled Dependent Team  
California Service Center  
1-800-731-4661 x3584



## MOST COMMONLY ASKED QUESTIONS

The purpose of this application is to ensure your dependent child's eligibility for coverage as a disabled individual under your group or personal plan. Information contained in this application is not disclosed to any other department or agency.

Why do I have to complete this application if my dependent has been on my plan for a long period of time?

- Kaiser Permanente is now requiring that all dependents listed as disabled to be certified or recertified every 1 or 2 years.

Application question #2: Dependents monthly living expenses:

- This is an estimate of monthly expenses.
- Rent/mortgage expense: total cost divided by the number of household members.
- Transportation: bus pass, gas for car, etc.
- Food: Cost of special diet or monthly grocery expense divided by the number of household members.
- Medical: Co-payments, deductibles, or cost of prescriptions.
- Clothing: Clothing allowance.
- Other: Any other expenses incurred or money spent on dependent.

Application question #3: Copy of tax return. Why must I provide it and do I need to send the entire document?

- Kaiser Permanente reserves the right to request proof of dependence not more than once every twelve (12) months. One form of proof is the tax form and only the first page is required.

Application question #4: Amount of aid received and type.

- Kaiser Permanente uses this information for our purposes only. Reminder, we do not report any information received to other departments or outside agencies.

Application question #5: Proof of dependents earnings. My dependent doesn't keep his/her pay stub. What else can I send?

- A memo from his/her employer stating date of hire, the hourly wage received, and approximate number of hours worked on a weekly basis is sufficient.

Statement of Authorized Representative:

- This form is to authorize you, the parent, to act on your disabled dependents behalf with the Disabled Dependent Department because he/she is over the legal age of 18. It also allows you, the parent, to receive personal health information regarding your dependent should we need that information.
- This form is required to process your application.

Dr. Statement (Part B): Why does the doctor have to complete this form?

- In an effort to protect your personal health information, medical records are not released outside the facility, therefore, Part B requires that only a Physician may complete this form.



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  
 Questions: 800-731-4661 x 3584  
 Tie Line: 8-279-3584

## 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: PLEASE PRINT or TYPE

SUBSCRIBER'S LAST NAME		FIRST NAME		M.I.	KP MEDICAL RECORD #
ADDRESS				TELEPHONE #	
CITY			STATE	ZIP CODE	
SOCIAL SECURITY #		GROUP #		EMPLOYER TELEPHONE #	
SUBSCRIBER'S EMPLOYER					

DEPENDENT'S LAST NAME		FIRST NAME		M.I.	KP MEDICAL RECORD #
ADDRESS				TELEPHONE #	
CITY			STATE	ZIP CODE	
DEPENDENT'S SOCIAL SECURITY #		APPLICANT'S BIRTHDATE(Mo/ Day/Yr)		RELATION TO SUBSCRIBER	

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

PHYSICIAN'S NAME	KFHP Facility or Physician Location/address	OFFICE TELEPHONE/ TIE LINE NUMBER
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## Disabled Dependent Enrollment Application

### Part A – Section IV – Subscriber Questionnaire

<b>Circle One</b>		<i>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.</i>		
<b>Yes</b>	<b>No</b>	<b>1.</b> Is the dependent currently enrolled on your account? If No, has the dependent been enrolled on your KFHP plan within the past 12 months prior to the date of this application? <b>Please explain:</b>  <hr style="border: 0; border-top: 1px solid black; margin: 5px 0;"/> <hr style="border: 0; border-top: 1px solid black; margin: 5px 0;"/>		
		<b>2.</b> Is the dependent reliant 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.) <b>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.</b>		
		<b>Dependent average monthly expense</b>	<b>Expense Type</b>	<b>*Other expense type explanation</b>
		\$	Housing/Rent	
		\$	Transportation	
		\$	Food/Toiletries	
		\$	Medical Care	
		\$	Clothing	
		\$	*Other	
		\$	*Other	
Total Monthly Expenses		\$		
<b>Yes</b>	<b>No</b>	<b>3.</b> Was the dependent claimed as a dependent on your or your spouse’s most recent federal tax return? <b>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:</b>  <hr style="border: 0; border-top: 1px solid black; margin: 5px 0;"/> <hr style="border: 0; border-top: 1px solid black; margin: 5px 0;"/>		
		<b>4.</b> Does the dependent qualify or receive any government-sponsored aid or income because of his or her disabled status? <b>If yes, please check all that apply:</b>		
		<b>Type of Aid</b>	<b>Amount of Benefit</b>	<b>Benefit Start Date</b>
		<input type="checkbox"/> Social Security Disability Insurance (SSD)?		
		<input type="checkbox"/> Supplemental Security Income (SSI)?		
		<input type="checkbox"/> Medi-Cal?	N/A	
		<input type="checkbox"/> Medicare Part A (Hospital)	N/A	
		<input type="checkbox"/> Medicare Part B (Medical Care)	N/A	
		<b>Other (Describe):</b>		



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## Disabled Dependent Enrollment Application

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

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

Subscriber's Signature





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## Disabled Dependent Enrollment Application

### PART B

Section I – To be completed by Dependent’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.**

DEPENDENT’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 DESCRIPTION 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.)			
<b>IN ADDITION TO THE INFORMATION REQUIRED ABOVE, PLEASE PROVIDE ANSWERS TO THE FOLLOWING QUESTIONS:</b>			
(Mo., Day, Year)			
1) DATE DISABILITY OCCURRED			
2) IN YOUR MEDICAL OPINION, IS THE DISABILITY: <b><u>MUST COMPLETE A – D.</u></b>			
A) MENTAL RETARDATION		YES <input type="checkbox"/>	NO <input type="checkbox"/>
B) PHYSICAL HANDICAP		YES <input type="checkbox"/>	NO <input type="checkbox"/>
C) BIOLOGICALLY BASED (Psychiatric Disorder)		YES <input type="checkbox"/>	NO <input type="checkbox"/>
D) IS MEDICAL INTERVENTION REQUIRED?		YES <input type="checkbox"/>	NO <input type="checkbox"/>
3) IN YOUR MEDICAL OPINION, IS THE DISABILITY LIKELY TO IMPROVE?			
		YES <input type="checkbox"/>	NO <input type="checkbox"/>
4) IN YOUR MEDICAL OPINION, IS THE APPLICANT CAPABLE OF SELF SUSTAINING EMPLOYMENT?			
		YES <input type="checkbox"/>	NO <input type="checkbox"/>
ATTENDING PHYSICIAN’S SIGNATURE			DATE
PHYSICIAN’S PRINTED NAME		KFHP Facility or Physician’s Mailing Address	
CITY	ZIP CODE	PHYSICIAN’S TELEPHONE OR TIE LINE #	



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## Disabled Dependent Enrollment Application

### 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 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.**

<b>DEPENDENT'S Name &amp; Address:</b>	
<b>Daytime Phone #:</b> ( )	<b>Alternate Phone #:</b> ( )
<b>Medical Record #:</b>	<b>Medicare #</b>

**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.

<b>Subscriber Name:</b> Subscriber's Name		
<b>Address:</b>		
<b>City:</b>	<b>State:</b>	<b>Zip:</b>
<b>Daytime Phone #:</b> ( )	<b>Evening Phone #:</b> ( )	

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).

**Dependent Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

*(If not possible, indicate "cannot write")*

### PART C:

I am authorized to sign this authorization on behalf of _____ and on the basis of:	
<input type="checkbox"/> Legal Authority (Power of Attorney, etc.)	<input type="checkbox"/> Written Designation by the Member
<input type="checkbox"/> Parent, Guardian or other individual acting in loco parentis	
<b>Parent / Guardian Signature:</b> _____	<b>Date:</b> _____