Healthy Kids HMO: Premium Assistance Request Form

Applicant Name:	
Case Number(if any):	Date:

Healthy Kids HMO AA Instructions: Premium Assistance (PA) is available for applicants who demonstrate financial hardship or other special circumstance. Please use one PA form per Healthy Kids HMO Application. All PA requests are subject to approval by the Healthy Kids HMO Program when funds are available. Premium assistance will be reflected on any invoices sent to applicants, if applicable. (Please print legible)

Name	Date of Birth
1.	_____/_____/_____
2.	_____/_____/_____
3.	_____/_____/_____
4.	_____/_____/_____

Financial Hardship: Please provide detailed reason for PA. (Use back side of form for additional space.)

I would like to request Premium Assistance for the persons listed above due to financial hardship. I agree to pay the annual premium after premium assistance is applied. If I do not pay the premium reflected on my invoice, I understand that my child/ren listed above may be removed from the Healthy Kids HMO program due to non-payment of premiums. I declare that the above information is true and correct to the best of my knowledge.

_____ _____

Signature of Applicant Date

MUST REVIEW BY HEALTHY KIDS HMO STAFF ONLY:

Outcome: ʘ Approve ʘ Deny

By Healthy Kids HMO Staff: _____

FPL%_____

Date: _____