KernMedical
WELLNESS PROGRAM

What is Kern Medical Wellness Program (KMWP)?
Kern Medical Wellness Program (KMWP) is a hospital managed wellness program designed to provide access to care for low-income, uninsured Kern County residents. Members will have access to Kern Medical facilities and treatment by some of the best medical professionals within our community. For those eligible, Kern Medical's health care services will be provided at discounted rates or little cost.

KMWP is not a health insurance plan. KMWP is designed to promote overall wellness for its member and provide access to limited wellness care primarily at Kern Medical facilities. KMWP does not cover the cost associated with care provided by Non-Kern Medical (out-of-network) providers or facilities. Members will be financially responsible for medical services, supplies and medications not offered as part of KMWP.

Kern Medical Wellness Program not intended to replace or provide medical insurance coverage. KMWP members are strongly encouraged to obtain health insurance coverage. KMWP members will periodically be scheduled to meet with Kern Medical Health Benefit Advisors to determine eligibility for state funded health insurance programs, such as Medi-Cal or Covered California.

Don't Wait until you're Sick to Seek Medical Care
KMWP Enrollees are assigned to a Kern Medical Clinic and have access to comprehensive primary and specialty care from doctors who are familiar with their medical histories and special medical needs.

Do you qualify?
If you are all of the following you may qualify for Kern Medical Wellness Program (KMWP):

- A Kern County resident (must be a Kern resident for the past 30 days)
- Not eligible for any other public insurance programs such as Medi-Cal or CHIP
- Between the ages of 19 and 64
- Living within program income guidelines

Enrollee Benefits
In addition to our program services, all KMWP enrollees receive a patient ID card, health education materials, a free newsletter subscription, and access to our Member Services toll free phone line.

How to Apply
To complete your application, here's what you need to do:

1. **Complete the application form and sign it.**
   Complete all items on the application and sign on page 3.

2. **Collect your documents.**
   On page 4 of the application, we have listed all applicable documents that must be submitted with your application. Please review this carefully.

3. **Mail your completed form and supportive documentation to:**
   Kern Medical Wellness Program
   1700 Mount Vernon Ave.
   Bakersfield, CA 93306

Applications may take up to 45 business days to process. Additional items may also be needed in some cases in order to determine eligibility. If needed, the Health Benefit Advisor will request additional items. If you have any questions, please call KMWP Financial Services at (661) 326-2392.

Kern Medical Wellness Program
1700 Mount Vernon Ave. Bakersfield, CA 93306 ~ Phone: (661)326-2392

Application

Please fill out all information on this form. Print clearly.
Use black or blue ink only.

Questions? Please call: 661-326-2392

Mail your completed form to:
Kern Medical Wellness Program
1700 Mount Vernon Ave.
Bakersfield, CA 93306

Tell us about the applicant filling out this form.

1. _____
   Last Name First Name Middle Initial
2. _____
   Home Address *(Number and Street)* Do NOT use a P.O. Box – unless homeless Apt. #
3. _____
   City State Zip Code
4. _____
   Mailing Address *(if different from above)* or P.O. Box Apt. #
5. _____
   City State Zip Email Address (optional)
6. _____
   Home Phone Work Phone Cell Phone

7. What Language do you want us to speak to you in? ☐ English ☐ Spanish ☐ Other: _____
8. What Language should we write to you in? ☐ English ☐ Spanish ☐ Other: _____

Tell us about those applying for KMWP and those living in the household.

List all family members who live in the home. Include spouse, children and/or stepparents living in the home. Do not list aunts, uncles, nieces, nephews, or grandparents.

		Applicant	Spouse	Child	Child
9			Is this person also applying for KMWP? ☐ Yes ☐ No	Is this person also applying for KMWP? ☐ Yes ☐ No	Is this person also applying for KMWP? ☐ Yes ☐ No
10	Name Last, First, MI				
11	Name on birth certificate (if different from name above)				
12	Home Address (if different from address in 2)				
13	Mailing Address (if different from address in 4)				
14	County of Residence	☐ Kern ☐ Other If other: _____	☐ Kern ☐ Other If other: _____	☐ Kern ☐ Other If other: _____	☐ Kern ☐ Other If other: _____
15	Date of Birth (mo/day/yr)	____/____/____	____/____/____	____/____/____	____/____/____

KMWP Application Last Revised 8/22/16

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KMWP

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16	Gender	☐ Male ☐ Female ☐ Other	☐ Male ☐ Female ☐ Other	☐ Male ☐ Female ☐ Other	☐ Male ☐ Female ☐ Other
17	Marital Status	☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated	☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated	☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated	☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated
18	Ethnicity – *Optional*	☐ Hispanic ☐ Latino ☐ Non-Hispanic	☐ Hispanic ☐ Latino ☐ Non-Hispanic	☐ Hispanic ☐ Latino ☐ Non-Hispanic	☐ Hispanic ☐ Latino ☐ Non-Hispanic
19	Race – *Optional*	☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other:	☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other:	☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other:	☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other:
20	Or foreign country				
21	Social Security No.				
22	U.S. Citizen or National? If *No*, date arrived in the U.S.	☐ Yes ☐ No ___/___/___	☐ Yes ☐ No ___/___/___	☐ Yes ☐ No ___/___/___	☐ Yes ☐ No ___/___/___
23	Primary Language				
24	Preferred Language				
25	KERN MEDICAL Medical Record # (if applicable)				
Other Insurance Information					
26	Does this person have other health insurance?	☐ Yes ☐ No If yes, complete next section	☐ Yes ☐ No If yes, complete next section	☐ Yes ☐ No If yes, complete next section	☐ Yes ☐ No If yes, complete next section
27	Insurance Name				
28	Group Number				
29	Insurance Phone Number				
30	Coverage type				
31	Effective Date				
32	Expiration Date (if applicable)				

KMWP Application Last Revised 8/22/16

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KMWP

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Family Income Information

Do you or any family member have any of the following sources of income? List all family income for the prior month, including child support and spousal support **received.**

Number of adults in household:_____ Number of children in household: _____

Source of Income	**Applicant** List the amount and how often the income is received (weekly, biweekly, monthly)	**Spouse** List the amount and how often the income is received (weekly, biweekly, monthly)	**Child** List the amount and how often the income is received (weekly, biweekly, monthly)
Employment status	☐ Full-Time ☐ Part-Time ☐ Unemployed ☐ Retired ☐ Self-Employed ☐ Volunteer ☐ Student ☐ Temporary	☐ Full-Time ☐ Part-Time ☐ Unemployed ☐ Retired ☐ Self-Employed ☐ Volunteer ☐ Student ☐ Temporary	☐ Full-Time ☐ Part-Time ☐ Unemployed ☐ Retired ☐ Self-Employed ☐ Volunteer ☐ Student ☐ Temporary
Job	$ *How often:*	$ *How often:*	$ *How often:*
Unemployment benefits If unemployed, what is the last date worked?	$ *How often:* _____/_____/_____	$ *How often:* _____/_____/_____	$ *How often:* _____/_____/_____
Social Security Disability benefits	$ *How often:*	$ *How often:*	$ *How often:*
Veterans Benefits	$ *How often:*	$ *How often:*	$ *How often:*
Social Security Retirement			
Social Security Survivors	$ *How often:*	$ *How often:*	$ *How often:*
Military Allotment	$ *How often:*	$ *How often:*	$ *How often:*
Payment form roomers	$ *How often:*	$ *How often:*	$ *How often:*
Interest/ dividends	$ *How often:*	$ *How often:*	$ *How often:*
Other:_____	$ *How often:*	$ *How often:*	$ *How often:*

Member Responsibilities:

I have read the KMWP Enrollment Form, and understand that by enrolling in the program:

- I agree to participate in KMWP and comply with the program requirements;
- I agree to attend all medical appointments made on my behalf;
- I agree to provide my care manager, physicians, nurses, and other health care and social service professionals with all appropriate information regarding my health;
- Upon signing this form, I will receive a copy.

I declare under penalty of perjury under California state law that I have read this application, the answers provided, and the documents enclosed and, to the best of my knowledge, they are correct and true.

_____ _____
Participant Signature Date

_____ _____
Witness (Kern Medical Staff) Signature Date

KMWP Application Last Revised 8/22/16

Application

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KMWP

Questions? Please call: 661-326-2392

Fill out below ONLY if a Certified Application Assistant (CAA) helped you fill out this form.

☐ Check this box and sign below to allow Healthy Families and Medi-Cal to speak to a representative of the Enrollment Entity (EE) listed below about the status of this Application. This permission ends when the program mails you its decision on this Application.

I certify the CAA listed below helped me complete this application. This CAA helped me for free.

Applicant Signature:_____ Date: _____

CAA#_____ EE# _____

CAA Signature:_____ Date: _____

Supportive Documentation for KMWP Application

Listed below are the majority of items needed for most persons to determine eligibility. Mail items with your completed application that you think may be of assistance in determining eligibility. Additional items may be needed in some cases in order to determine eligibility. If needed, the financial counselor will request additional items.

1. Proof of Kern County Residency (e.g. utility bill)
2. Valid Picture Identification
3. Proof of U.S. Citizenship or Legal Residency **(Required from KMWP Select)**
    a. Birth Certificate
    b. U.S. Passport
    c. Adoption Papers
    d. Military Record showing birth in the U.S.
    e. Report or Certification of Birth Abroad of a U.S. citizen (form FS-240 or FS-545)
    f. U.S. Citizenship I.D. Card (DHS I-197)
    g. Permanent Resident Card ("Green Card") (Client Alien Registration Number)
4. Social Security card for all applicants
5. Verification of *all* income in household
    a. Earnings
    b. Unemployment Income (UIB)
        i. Unemployment print-out 1-800-300-5616
    c. State Disability Income (SDI)
    d. Social Security Income (SSI)/Social Security Disability (SSD)
    e. Other (Profit & Loss Statement)
6. Record of application/ denial for Social Security Disability (SSD), Social Security Income (SSI), Medi-Cal, Unemployment Income (UIB), State Disability Income (SDI), Workman's Comp Income (WCI)

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