



Patient's Name \_\_\_\_\_

**Requesting financial assistance for**

Transportation

Mode \_\_\_\_\_ Cost \$ \_\_\_\_\_

Tuition Cost \$ \_\_\_\_\_

Are the above costs covered by any other source?  Yes  No

If yes, please explain \_\_\_\_\_  
\_\_\_\_\_

Other (please explain)

\_\_\_\_\_  
\_\_\_\_\_

Make check payable to:

Patient (or parent)

Other (please specify payee and address)

Camp

\_\_\_\_\_  
Name

\_\_\_\_\_  
Address City State Zip

**I ATTEST** that the information provided in this application is complete and accurate to the best of my knowledge.

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\_\_\_\_\_  
Social Worker's Signature Date

\_\_\_\_\_  
Doctor's Signature Date

\_\_\_\_\_  
Social Worker's Name (please print)

\_\_\_\_\_  
Doctor's Name (please print)

\_\_\_\_\_  
Corporate Name

\_\_\_\_\_  
Facility Name

\_\_\_\_\_  
Address

\_\_\_\_\_  
City State Zip

\_\_\_\_\_  
\*Telephone \*Fax

\_\_\_\_\_  
\*E-Mail Address

**\*Very Important**

**A photograph is not required,  
but we would appreciate one if available.**

**All photos become the sole property of the  
American Kidney Fund.**

