



American Kidney Fund®

Health Insurance Premium Program

APPLICATION

(For Dialysis Patients only)

Mail or fax completed form to:

AKF Patient Services, 6110 Executive Blvd., #1010, Rockville, MD, 20852

Regular Fax: (240)-514-3510

Urgent Fax: (240)-514-3515

Questions? Phone 1-800-795-3226 or Email: patientservice@kidneyfund.org

Incomplete applications will be returned. Please read program guidelines first.

Part 1: Dialysis Center Information

Facility Name: _____

Facility Number: _____

Corporate Affiliation _____

Street Address 1 _____

Street Address 2 _____

City, State, Zip _____

Phone number (_____) _____ Fax number (_____) _____

Renal Professional Contact (printed) _____

Renal Professional's email address (required): _____

Part 2: Patient Information

Social Security Number _____ - _____ - _____ Date of Birth / ____ / ____

Name _____
First MI Last

Mailing Address _____ Apt# _____

City _____ State _____ Zip _____

Phone (_____) _____ Gender: Male Female

Email address _____

Part 3: Additional Information

Individual patient data is kept in strict confidence by AKF. From time to time, AKF aggregates data from many patients to create aggregated (summary) patient data. This aggregated (summary) data makes it impossible to identify individual data. AKF may share this aggregated (summary) data with third parties, including researchers, partners, foundations, policy makers and other funding sources to help us apply for funding, prepare reports, advocate on behalf of patients, or perform other health related research. You may choose not to participate by selecting the box "I do not wish to respond" and it will in no way affect grant status.

Marital Status:

- Married/Domestic Partnership
- Divorced Single
- Widowed

Are You Employed?

- Yes
- No
- If Yes - Part-time Full-time

Total # in household _____

Race/Ethnicity: (Please check one)

- American Indian or Alaskan Native
- Asian
- Black/African American
- Hispanic or Latino
- Native Hawaiian or Other Pacific Islander
- White or Caucasian-Not Hispanic or Latino
- I Do Not Wish to Respond

What is your Kidney Diagnosis?

- Hypertension
- Glomerulonephritis
- Diabetes
- Genetic/Congenital Kidney Disease (PKD)
- Cancer
- Other Urologic Reason
- Unknown
- Other _____
- I Do Not Wish to Respond

What is your Current Status?

- Dialysis Patient – Never Transplanted
 - Dialysis Patient – Post Transplant
 - Kidney Donor (Check one) related nonrelated
- First ESRD treatment date (Required)** ____/____/____

What is your Treatment Modality?

- In-center hemodialysis
- Conventional home hemodialysis
- Daily home hemodialysis
- Nocturnal home hemodialysis
- Continuous Ambulatory Peritoneal Dialysis (CAPD)
- Continuous Cycling Peritoneal Dialysis (CCPD)
- Automated Peritoneal Dialysis (APD)

Transplant Patient

Date of First Transplant (Required) ____/____/____
 Date of First Transplant Failure (if applicable) ____/____/____
 Date of Second Transplant (if applicable) ____/____/____
 Date of Second Transplant Failure (if applicable) ____/____/____

Type and Site of Vascular Access? (if applicable)

- Arteriovenous (AV) Fistula - Forearm (Radial-cephalic Fistula)
- Arteriovenous (AV) Fistula - Upper arm (Brachial-cephalic or Brachial-basilic Fistula)
- Arteriovenous (AV) Graft - Forearm
- Arteriovenous (AV) Graft - Upper arm (Axillary Graft)
- Arteriovenous (AV) Graft - Thigh (Femoral Graft)
- I Do Not Wish to Respond
- Arteriovenous (AV) Graft - Chest (Axilloaxillary or Necklace Graft)
- Central Venous Catheter - Neck (External or Internal Jugular Catheter, Tunneled Catheter or Perma-Cath)
- Central Venous Catheter - Chest (Subclavian Catheter)
- Central Venous Catheter - Leg/Groin (Femoral Catheter)

Nephrologist Information:

Nephrologist's name (printed) _____
 Office phone number (____) _____ ext. ____ Fax number (____) _____

Part 4: Request for Assistance

Are you eligible for the following sources of financial assistance?

1. Do you have Medicare? Yes No Circle all that apply: Part A B C D
2. Do you have or are you eligible for Medicaid? Yes No
 If yes, explain benefit: I have a monthly spend-down of \$ _____
 Pays for my Medicare premium
 Covers 20% of my dialysis treatments
 I am eligible but choose not to apply for or use the benefit
3. State Renal /Kidney Program Yes No
 If yes, explain coverage: Pays for one or more of my insurance premiums
 Covers 20% of my dialysis treatments
 I am eligible but choose not to apply for or use the benefit
4. Reimbursement through an employer flexible spending plan Yes No

Part 5: Patient Financial Information

Complete financial information is required on all household members.

<p>Household Assets</p> <p>Checking Acct. \$ _____</p> <p>Savings Acct. \$ _____</p> <p>Home Assessed Value \$ _____</p> <p>Stocks & Bonds \$ _____</p> <p>Auto Year/Make _____</p> <p>MONTHLY Household Income</p> <p>Take Home Pay \$ _____</p> <p>Spouse's Take Home Pay \$ _____</p> <p>Addl. Household Income \$ _____</p> <p>Child Support \$ _____</p> <p>Food Stamps \$ _____</p> <p>Retirement Income \$ _____</p> <p>SSI/SSD benefit \$ _____</p> <p>Veteran's benefits \$ _____</p> <p>Other (Specify) \$ _____</p> <p>Total Monthly Income \$ _____</p>	<p>MONTHLY Household Expenses</p> <p><input type="checkbox"/> Rent <input type="checkbox"/> Mortgage \$ _____</p> <p>Food \$ _____</p> <p>Phone(s) \$ _____</p> <p>Gas \$ _____</p> <p>Electricity \$ _____</p> <p>Water \$ _____</p> <p style="text-align: center;">Transportation</p> <p>Auto Payment(s) \$ _____</p> <p>Taxi Fee/Gasoline \$ _____</p> <p style="text-align: center;">Medical Expenses</p> <p>Patient's Medication \$ _____</p> <p>Family Medications \$ _____</p> <p style="text-align: center;">Other</p> <p>Health Insurance. \$ _____</p> <p>Life Insurance. \$ _____</p> <p>Auto Insurance \$ _____</p> <p>Credit Accounts \$ _____</p> <p>Loans (Specify) \$ _____</p> <p>Misc. (Specify) \$ _____</p> <p>Total Monthly Expenses \$ _____</p>
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If monthly income is left blank, specify reason:

Are any of the expenses listed above covered by another source? Partially Fully None
 Please explain below:

Part 6: Patient and Renal Professional Signature Confirmation

I give my written consent for a licensed health care professional or Renal Professional (any agent/representative from the submitting organization/company) to act as my agent in connection with completing an American Kidney Fund Grant Application either in written format or online, and has my permission to update personal data on my behalf.

I attest that the information provided is complete and accurate to the best of my knowledge and may be verified by AKF. I have read the program guidelines and understand the conditions of participation. I agree to abide by the terms and rules of the program.

I agree that AKF may disclose my social security number (as an identifier) and/or application information to my health insurance carrier, dialysis caregivers, pharmacist, or other party to fulfill my grant request.

I understand that AKF's role in providing financial assistance for any products included in this program does not imply product endorsement or liability for use or misuse.

I further understand that assistance will terminate if AKF becomes aware of any fraudulent behavior associated with this request.

I also understand that applications will be processed on a first come, first served basis. While every effort will be made to provide assistance, this Program is limited to the availability of funds and may be modified or discontinued at any time without notice.

Patient's Name (Please Print)

Patient's Signature Date

Renal Professional Confirmation
The applicant is a patient at the dialysis facility listed above.
Renal Professional's signature _____