



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

Fax: (301) 881-3311

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 _____

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 (Axillary Graft)
- 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 3: 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 4: 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:
