

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: 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 5: 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
- Transportation assistance is available (car service or reimbursement)
Amt/mo, if reimbursed \$ _____
- I am eligible but choose not to apply for or use the benefit

3. State Renal /Kidney Program Yes No

- If yes, explain coverage: Medication assistance
- Transportation assistance (car service or reimbursement)
amt/mo \$ _____
- I am eligible but choose not to apply for or use the benefit

4. Commercial Pharmacy Prescription Benefit Yes No

5. Programs of All-Inclusive Care for the Elderly (PACE) Yes No

6. State Pharmacy Assistance Program (SPAP) Yes No

7. Pharmaceutical Manufacturer Patient Assistance Programs Yes No

If yes, list program(s), benefit and last date that you received help.

8. Reimbursement through an employer flexible spending plan Yes No

Maximum grant amount provided per application is \$175. Please refer to the program guidelines for complete grant cap information for specific aid types, as some vary. You may choose **one** area of assistance per application only.

1. Pharmacy Needs: (Note: *Product is provided in most instances, except for patients with co pays)

- Medication Co pays (Attach an itemized list of the monthly cost)
- Medication assistance for (product name) _____
- Renal Vitamins Name _____
- Nutritional Supplement Name _____
- Special bandages Name _____

* Be sure to attach a prescription for medications and prescription renal vitamins – no refills will be provided. Refer to guidelines for specific prescription information.

2. Durable medical supplies: (Item will be provided)

- BP Cuff
- Glucometer (if not covered under Medicare or Insurance)

3. Transportation monthly cost or co pay \$ _____ (if applicable)

- Gasoline Car Repairs/tires (attach a bill or estimate)
- Cab/ Bus Provider/Van Service

4. Kidney Donor & Transplant Expenses (check all that apply)

- Transportation Lost wages during recovery
- Lodging Pre/post-transplant dental work (attach bill or estimate)

5. Mobility Aids

- Wheel chair (including repair) Walker or cane
- Wheel chair ramp

6. Transient Dialysis (Due to family illness, death or transplant workup)

Reason: Family Illness Death Transplant Workup Date of Service

Date(s) Of Service (Attach bill or receipt no more than 4 weeks old):

Name of Transient dialysis center/address _____

7. Home Hemodialysis (Attach a bill or receipt)

- Plumbing/Electrical modifications
- Special chair
- Portable machine
- Storage space
- Training -related expenses (Lodging, Transportation, etc.)

Amount requested \$ _____

(Make check payable to Patients (or parent)

Other (please specify payee and address)

Street address _____

City, State, zip _____

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 _____