



Dialysis Center Emergency Fund APPLICATION

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.

Facility Information:

Name of Dialysis Facility: _____

Parent Company _____

Street Address: _____

City State Zip

Telephone Number () _____

Fax Number () _____

Renal Professional Contact (please print) _____

Renal Professional Email address (required) _____

Additional Contact (please print) _____

Email address (required) _____

Check Payee _____

This Emergency Fund is established in the name of the treatment facility for the benefit of patients in emergency situations. The accountability for the Emergency Fund is the responsibility of the facility (not the individual who manages the Fund) Therefore, any money that is not accounted for by receipts submitted to the Fund must be replaced by the facility.

We accept and agree to the above statement.

Facility Representative _____ Signature Date