



**Part 2: Patient Financial Information**

*Complete financial information is required on all household members.*

<p><b>Household Assets</b></p> <p>Checking Acct. \$ _____</p> <p>Savings Acct. \$ _____</p> <p>Home Assessed Value \$ _____</p> <p>Stocks &amp; Bonds \$ _____</p> <p>Auto Year/Make _____</p> <p><b>MONTHLY Household Income</b></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><b>Total Monthly Income \$ _____</b></p>	<p><b>MONTHLY Household Expenses</b></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;"><b>Transportation</b></p> <p>Auto Payment(s) \$ _____</p> <p>Taxi Fee/Gasoline \$ _____</p> <p style="text-align: center;"><b>Medical Expenses</b></p> <p>Patient's Medication \$ _____</p> <p>Family Medications \$ _____</p> <p style="text-align: center;"><b>Other</b></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><b>Total Monthly Expenses \$ _____</b></p>
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If monthly income is left blank, specify reason:

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

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**Part 3: Request for Assistance**

Are you eligible for the following sources of financial assistance for your insurance premium?

- 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: Facility Information**

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

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): \_\_\_\_\_

Nephrologist's name (printed) \_\_\_\_\_

Office phone number (\_\_\_\_) \_\_\_\_\_ ext.\_\_\_\_ Fax number (\_\_\_\_) \_\_\_\_\_

**Renal Professional Confirmation**

**The applicant is a patient at the dialysis facility listed above.**

**Renal Professional's signature** \_\_\_\_\_

**Part 5: 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.**

1. Race: (check all that apply)

- 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

2. What is your Kidney Diagnosis?

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

3. Type and Site of Vascular Access? (if applicable)

- |  |   |
|--|---|
| <ul style="list-style-type: none"> <li><input type="checkbox"/> Arteriovenous (AV) Fistula - Forearm (Radial-cephalic Fistula)</li> <li><input type="checkbox"/> Arteriovenous (AV) Fistula - Upper arm (Brachial-cephalic or Brachial-basilic Fistula)</li> <li><input type="checkbox"/> Arteriovenous (AV) Graft - Forearm (Axillary Graft)</li> <li><input type="checkbox"/> Arteriovenous (AV) Graft - Upper arm (Axillary Graft)</li> <li><input type="checkbox"/> Arteriovenous (AV) Graft - Thigh (Femoral Graft)</li> <li><input type="checkbox"/> I Do Not Wish to Respond</li> </ul> | <ul style="list-style-type: none"> <li><input type="checkbox"/> Arteriovenous (AV) Graft - Chest (Axilloaxillary or Necklace Graft)</li> <li><input type="checkbox"/> Central Venous Catheter - Neck (External or Internal Jugular Catheter, Tunneled Catheter or Perma-Cath)</li> <li><input type="checkbox"/> Central Venous Catheter - Chest (Subclavian Catheter)</li> <li><input type="checkbox"/> Central Venous Catheter - Leg/Groin (Femoral Catheter)</li> </ul> |
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**Part 6: Patient Signature:**

I attest that I have received and read a copy of the HIPP Patient Guidelines and understand the conditions of participation. I agree to abide by the terms and rules of the program.

I attest that the information provided is complete and accurate to the best of my knowledge and may be verified by AKF.

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 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.

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Patient's Signature

Date

**Note:**  
**This application must be accompanied by a HIPP Request Form and a current insurance premium bill or statement. Please be sure to complete the entire application. Incomplete applications will be returned**