



**Safety Net Program  
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](mailto:patientservice@kidneyfund.org)

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

**Part 1: 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 \_\_\_\_\_

**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)

**What is your Current Status?**

- Dialysis Patient – Never Transplanted

**First ESRD treatment date (Required)** \_\_\_\_/\_\_\_\_/\_\_\_\_

- Dialysis Patient – Post Transplant

**Date of First Transplant (Required)** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Date of First Transplant Failure (Required)** \_\_\_\_/\_\_\_\_/\_\_\_\_

**First ESRD treatment date – Post Transplant (Required)** \_\_\_\_/\_\_\_\_/\_\_\_\_

Date of Second Transplant (if applicable) \_\_\_\_/\_\_\_\_/\_\_\_\_

Date of Second Transplant Failure (if applicable) \_\_\_\_/\_\_\_\_/\_\_\_\_

- 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) \_\_\_\_/\_\_\_\_/\_\_\_\_

- Kidney Donor

(Check one)  related  nonrelated

**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?**

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.

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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:  Patient (or parent)

Other (please specify payee and address)

\_\_\_\_\_

Street address \_\_\_\_\_

City, State, zip \_\_\_\_\_

**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 or transplant 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

**(Additional Information cont.)**

**3. 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)

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**Part 6: Patient Signature:**

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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.

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Patient's Signature

Date

**Please be sure to complete the entire application. Incomplete applications will be returned.**