National Kidney Foundation of FLORIDA

Priority Application
Yes ☐ No ☐
Resubmission of denied application
Yes ☐ No ☐

Mail NKF of Florida – Direct Aid
1040 Woodcock Dr, Ste 119
Orlando, FL 32803
3407-894-7325 800-927-9659
Fax 407-895-0051
www.kidneyfla.org

PATIENT APPLICATION FOR FINANCIAL ASSISTANCE

Name First Middle Last

Address

City State Zip

Date of Birth County

( ) __ __ __-__ __ -__ __ __ __
Telephone Social Security Number

Spouse's Name (or if applicant is a child give Parents or guardian's name)
Disabled Yes ☐ No ☐

Date of Birth Health Status

No. of dependents in household and ages

New to Dialysis Yes ☐ No ☐ Date _____

Medicare? Yes ☐ No ☐

Medicaid? Yes ☐ Pending ☐ Denied ☐

Medically Needy? ☐ or QMB? ☐

Insurance? Yes ☐ No ☐ HMO? Yes ☐ No ☐
Transplant Patient/Transplant Date_____

No of individuals in household _____ Relationship to Patient _____ Other members Employed? _____

ASSETS

Stocks/Bonds $ _____
Bank Accounts: Checking $ _____
Savings $ _____
Home Assessed Value $ _____
Auto: Year and Make _____

LIABILITIES

Loans $ _____
$ _____
$ _____
Other debts $ _____

MONTHLY INCOME

Employer Name _____
Spouse's Employer Name _____
Monthly Take Home Pay..... $ _____
Spouse's Monthly Take Home Pay..... $ _____
Social Security..... $ _____
SSI/SSDI..... $ _____
AFDC..... $ _____
Retirement Income..... $ _____
Veteran's Benefits..... $ _____
Food Stamps..... $ _____
Child Support..... $ _____
Other _____ $ _____
TOTAL MONTHLY INCOME $ _____

MONTHLY EXPENSES

Rent or Mortgage..... $ _____
Food..... $ _____
Telephone..... $ _____
Cell phone..... $ _____
Electricity..... $ _____
Gas..... $ _____
Water..... $ _____
Taxes..... $ _____
Auto Payment..... $ _____
Gasoline..... $ _____
Treatment Related Transportation..... $ _____
Hospital Payments..... $ _____
Patients Medications..... $ _____
Family Members' Medications..... $ _____
Medical Insurance..... $ _____
Auto Insurance..... $ _____
Other Insurance..... $ _____
Loans..... $ _____
Cable T.V..... $ _____
Credit Card..... $ _____
Other..... $ _____
TOTAL MONTHLY EXPENSES $ _____

Specify the type of assistance being requested: (Check one)

☐ Food/Suppl. ☐ Transportation ☐ Rent/Mortgage
☐ Publix ☐ Gas Cards ☐ Other
☐ WinnDixie ☐ Medical Equipment
☐ Other ☐ Medications
☐ Utilities ☐ Eye glasses
☐ **Monthly** ☐ **One time** **Amount $** _____

Check payable to: _____
Checks **cannot** be made payable to applicant; write in name of vendor such as transportation company, IVPP, or Rent/Mortgage Agent

Social Worker Name _____

Facility _____

Address _____

City _____ **Zip** _____

Phone _____ **Fax** _____

Email: _____

FOR OFFICE USE ONLY

Date _____ **Approved** ☐ **Denied** ☐

Start _____ **End** _____

ID# _____ **Amount$** _____

Payee _____

Check all sources of assistance applied for by the patient.

Explain benefits or why applicant doesn't qualify

☐ Personal/Family/Church/Charity _____

☐ Local/State Resources Utility Co _____ Telephone Co. _____ County funds _____

☐ Health Insurance Coverage _____ AKF HIPP _____

☐ COBRA . _____ AKF HIPP _____

_____

☐ Vocational Rehabilitation _____

☐ SSI/SSD Applied for _____

☐ Medicare applied for Yes ☐ No ☐ Expected Eff Date _____

☐ Pharmaceutical Assistance Programs _____

☐ Food Stamps Amount $_____ Food Banks _____ Share _____

☐ Transportation Medicaid Co Pay $_____ ADA Co Pay $_____ TD Co pay $_____

SOCIAL WORKER'S EXPLANATION

The narrative *MUST* include the following pertinent information. Provide a complete and detailed explanation of the circumstances which require this application for emergency assistance. Incomplete or unclear narratives will cause the application to be denied.

- **Explain why the applicant or family mebers are unable to work, or describe the applicant's job.**
- **Include patient's plan to handle future expenses**

I attest that the information in this form is complete and accurate to the best of my knowledge.

Social Worker Signature _____ **Date** _____

MEDICAL STATEMENT

1. Date of first dialysis _____ 2. Diagnosis _____

3. What are other medical conditions, if any _____ 4. Is the patient a candidate for transplantation? _____

Physician's Name (Print) _____ Physician's Telephone _____

In submitting this application, the applicant guarantees its accuracy and truth with the intent that it be relied upon by the National Kidney Foundation of Florida, Inc. in considering assistance to the undersigned. The applicant also agrees that the information in this application may be verified.

ApplicantSignature _____ Date _____