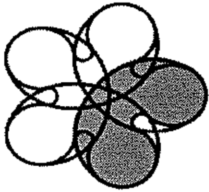

NATIONAL KIDNEY FOUNDATION OF THE ALLEGHENIES

700 Fifth Avenue 4th Floor
Pittsburgh, PA 15219
Phone (412) 261-4115 Fax (412) 261-1405
www.kidneyall.org

Patient Crisis Grant Application

Date of Application	
Amount Requested	

TO BE COMPLETED BY NKFALL STAFF	
Amount Approved	*Initials*
Date Approved	
Specific Funds	

Please check one box: (Note: One request per year)

☐ Interim Transportation ☐ Crisis Intervention Fund ☐ Nutritional Supplements
Paid quarterly - ongoing need must be documented.

Grant funds will be used for the specific purpose of:

Checks are typically payable to a third party. If you are requesting payment be made directly to patient, explain Special Circumstances below.

Make check payable to:
Address
City State Zip County
Phone E-mail

Patient Name: Age
Permanent Address Apt # SS#
City State Zip (SS# needed ONLY when grant request is $600 or more)
Phone: E-mail County

Dialysis or Transplant Unit Phone #
Unit Mailing Address
Patient's Social Worker Phone # E-Mail
Patient's Doctor Phone # E-Mail

Total ALL family sources of income: $____________

Check all boxes that apply

☐ Wages ☐ Social Security (SSI/SSDI) ☐ Investment Income ☐ Alimony
☐ Cash Assistance ☐ Supploemental Insurance ☐ Other(s):____________

List major expenses	*Check One Box*	*Month*	*Week*	*Annual*			*Month*	*Week*	*Annual*
1 Mortgage/Rent/Housing	$	☐	☐	☐	9 Car Payment(s):	$	☐	☐	☐
2 Homeowners/Renters Insurance	$	☐	☐	☐	10 Car Insurance	$	☐	☐	☐
3 Utilities: Gas	$	☐	☐	☐	11 Health Insurance	$	☐	☐	☐
4 Utilities: Light	$	☐	☐	☐	12 Medications	$	☐	☐	☐
5 Utilites: Water/Sewage	$	☐	☐	☐	13 School	$	☐	☐	☐
6 Utilities: Phone	$	☐	☐	☐	14 Other	$	☐	☐	☐
7 Utilities: Cable	$	☐	☐	☐	15 Other	$	☐	☐	☐
8 Groceries	$	☐	☐	☐	16 Other	$	☐	☐	☐

Special Circumstances:

Has patient previously requested NKFALL grant funds? ☐ Yes ☐ No

Date of prior request ____________ Amount of prior request ____________

Purpose of prior request Was this request granted ☐ Yes ☐ No

Have ALL other sources of financial aid been investigated prior to submitting this request? ☐ Yes ☐ No
Please list all agencies and individuals who were contacted for aid and the results of each inquiry.
Be sure to list name, address, name of person you spoke with and his or her telephone number.

#			
1	Agency Name		
	Agency Contact	E-mail	Phone Number
	Results of Inquiry		
2	Agency Name		
	Agency Contact	E-mail	Phone Number
	Results of Inquiry		
3	Agency Name		
	Agency Contact	E-mail	Phone Number
	Results of Inquiry		
4	Agency Name		
	Agency Contact	E-mail	Phone Number
	Results of Inquiry		
5	Name		
	Relationship	E-mail	Phone Number
	Results of Inquiry		

If the request is for Interim Transportation, has the patient applied to the PA Renal Transportation Program?

☐ Yes ☐ No Date of Application: ____________

Was request approved? ☐ Yes ☐ No ☐ Awaiting determination

What is the period funds will cover? (Maximum three months)

Starting Month ____________ Year ________ Ending Month ____________ Year ________

Transportation to dialysis center:

Cost per trip $____________ Number of miles each way #____________

What is the patient's plan for regular transportation? ____________

Receipts for transportaion must be attached to this application. Personal vehicles are not eligible for funding.

Additional Comments ____________

Patient Signature:	*Date*
Social Worker Signature:	*Date*

This form will not be processed unless all information is completed and all documentation is attached.