National Kidney Foundation of MICHIGAN

NKFM Case # _____

Luann Scheppelmann-Eib
Patient Emergency Fund Application

Return completed application to the National Kidney Foundation of Michigan at 1169 Oak Valley Drive, Ann Arbor, MI 48108. If you have any questions call 1-800-482-1455 or 734-222-9800. Fax number is 734-222-9801.

PATIENT TO COMPLETE THIS SECTION

Name: _____ Social Security #: _____

Address: _____ County: _____

City: _____ Zip: _____ Date of Birth: _____

Phone Number: (_____) _____ Number of Dependents _____

MONTHLY HOUSEHOLD INCOME:

Yours: $ _____ Source _____

Other: $ _____ Source _____

(Spouse, parent, adult child, etc.)

Total: $ _____

Number of people dependent on household income: _____

MONTHLY EXPENSES:

Housing (rent, mortgage, property taxes)	$ _____
Utilities (gas, electric, phone, water)	_____
Insurance (health, life, auto, home)	_____
Food	_____
Transportation (gasoline, taxi fare, bus)	_____
Loans (auto, credit card payments, etc.)	_____
Clothing	_____
Medication expenses	_____
Other monthly expenses (specify)	_____
_____	
Total	$ _____

HOUSEHOLD ASSETS:

Checking Account: $ _____

Bank Name: _____

Savings Account: $ _____

Bank Name: _____

Home (Assessed Value) _____

Stocks & Bonds: _____

Automobile: _____

Year/Make: _____

HOUSEHOLD LIABILITIES: (Loans/Debts)

Bank Name: _____ _____

Bank Name: _____ _____

Others (Specify): _____ _____

_____ _____

Amount Requested: _____

Applicant information continues on back →

THIS SECTION IS OPTIONAL

The following section is optional. Any information you provide will be kept strictly confidential. Your name will **NOT** be shared with anyone.

The National Kidney Foundation of Michigan receives funding for programs and services like this one from the United Way. In order to help us keep this funding, please fill out the following chart. Tell us the employer, union (if unionized) and retirement status for the wage earners in your family, including yourself and another wage earner (if there is one). We do not need the name of the wage earners, only their employer, union and retirement status. The information you provide is strictly confidential.

	First Wage Earner	Second Wage Earner
Employer		
Union Affiliation		
Retired (yes/no)		

Please specify your need for which funds are to be used:_____

_____

Check to be written in name of (can't be applicant):_____

In submitting this application, the patient guarantees its truth and accuracy. The patient also agrees that the information in this application may be verified. **Please attach receipts or additional documentation.**

Signature:_____ Date:_____

SOCIAL WORKER

Please review this patient's application for benefits from the NKFM's Patient Emergency Fund and provide us with the following additional information. Your completion of this form in its entirety will facilitate prompt consideration of this request.

Modality

- ❒ Transplant
- ❒ Hemodialysis
- ❒ CAPD
- ❒ CCPD
- ❒ Other _____

Health Insurance
(check all that applies)

- ❒ Medicare
- ❒ Blue Cross
- ❒ Medicaid
- ❒ Special Health Care Services
- ❒ HMO Specify _____
- ❒ Other Specify _____

Prescription Coverage

- ❒ Medicaid (Spend-down $_____)
- ❒ Deductible per prescription $_____
- ❒ Reimbursement for prescriptions_____%
- ❒ No Prescription Coverage

Because of the limited funds available, the National Kidney Foundation of Michigan's Patient Emergency Fund is to be considered a "last resort" when alternate sources of assistance are not available. Please indicate whether the patient is eligible for the following resources and whether they have been considered as sources of funding for the current need.

Resource	Yes	No	Explain
Medicare			
Medicaid			
Special Health Care Services			
State Vocational Rehabilitation			
Private Health Insurance			
Veteran's Benefits			
Church/other charitable organization			
Other Resources			

Please provide us with your comments and recommendations regarding this patient's need for financial assistance.

_____

_____

_____

Social Workers Name:_____

Facility Name:_____ Phone: (____)_____

Facility Address:_____