American Kidney Fund
11921 Rockville Pike
Suite 300
Rockville, Maryland 20852

Safety Net Program Application

Worksheet Only: Not to Be Submitted To AKF

All Applications Must Be Submitted VIA AKF's Grants Management System

Questions? Phone 1-800-795-3226 or Email: **patientservice@kidneyfund.org**

Please read program guidelines first.

Part 1: Dialysis Center Information

Facility Name: _____

Facility Number: _____

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): _____

Part 2: Patient Information

Social Security Number _____-_____-_____ Date of Birth /_____/_____

Name_____
First MI Last

Mailing Address _____Apt#_____

City_____ State _____ Zip_____

Phone (_____) _____ Gender: ☐Male ☐Female

Email address_____

Part 3: 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.

Additionally, AKF may retain one or more third parties to perform research to enable AKF to further pursue its mission by contacting you and other persons whom AKF assists. In this regard, AKF will **disclose only** your name, address, e-mail address and phone number to permit such third party researchers to contact you to carry out such research.

If you do not wish to respond to any of the questions set forth below by checking the "I do not wish to respond" box, your decision will not affect your grant status. If you do not want AKF to disclose your name, address, e-mail address or phone numbers to third party researchers, please check the box set forth below indicating that you do not want AKF to disclose your name or contact information. This decision also will not affect your grant status.

Marital Status:
❒ Married/Domestic Partnership
❒ Divorced ❒ Single
❒ Widowed

Are You Employed?
❒ Yes
❒ No
If Yes - ❒ Part-time ❒ Full-time

Total # in household_____

Race/Ethnicity: (Please check one)

❒ American Indian or Alaskan Native
❒ Asian
❒ Black/African American
❒ Hispanic or Latino
❒ Native Hawaiian or Other Pacific Islander
❒ White or Caucasian
❒ Multiracial
❒ I Do Not Wish to Respond

What is your Kidney Diagnosis?

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

What is your Current Status?
❒ Dialysis Patient – Never Transplanted
❒ Dialysis Patient – Post Transplant
First ESRD treatment date (Required) ____/_____/_____
❒ Kidney Donor (please check ❒ Related ❒ Nonrelated)

What is your Treatment Modality?
❒ In-center hemodialysis
❒ Conventional home hemodialysis
❒ Daily home hemodialysis
❒ Nocturnal home hemodialysis
❒ Continuous Cycling Peritoneal Dialysis (CCPD)
❒ Automated Peritoneal Dialysis (APD)
❒ Continuous Ambulatory Peritoneal Dialysis (CAPD)

❒ 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____/_____/_____

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)
❒ 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)
❒ I Do Not Wish to Respond

Nephrologist Information:

Nephrologist's name (printed) _____

Office phone number (_____) _____ ext._____ Fax number (____) _____

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Part 4: Patient Financial Information

Complete financial information is required on all household members.

Household Assets	**MONTHLY Household Expenses**
Checking Acct. $_____	☐ Rent ☐ Mortgage $_____
Savings Acct. $_____	Food $_____
Home Assessed Value $_____	Phone(s) $_____
Stocks & Bonds $_____	Gas $_____
Auto Year/Make _____	Electricity $_____
	Water $_____
	Transportation
MONTHLY Household Income	Auto Payment(s) $_____
Take Home Pay $_____	Taxi Fee/Gasoline $_____
Spouse's Take Home Pay $_____	***Medical Expenses***
Addl. Household Income $_____	Patient's Medication $_____
	Family Medications $_____
Child Support $_____	***Other***
Food Stamps $ _____	Health Insurance. $_____
Retirement Income $_____	Life Insurance. $_____
SSI/SSD benefit $_____	Auto Insurance $_____
Veteran's benefits $_____	Credit Accounts $_____
	Loans (Specify) $_____
Other (Specify) $_____	Misc. (Specify) $_____
Total Monthly Income $_____	**Total Monthly Expenses** $_____

If monthly income is left blank, specify reason:

_____

_____

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

_____

_____

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Part 5: 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.

_____

_____

_____

8. Reimbursement through an employer flexible spending plan ❒ Yes ❒ No

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*Maximum grant amount provided per application is $100. 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(s) Of Service (Attach bill or receipt no more than 12 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 ❒ Patients (or parent)

❒ Other (please specify payee and address)

_____

Street address_____

City, State, zip _____

This page may be submitted to AKF in lieu of the GMS generated consent form

Part 6: Patient and Renal Professional Signature Confirmation

I understand that I may register to use AKF's Grants Management System (GMS) by logging on to www.kidneyfund.org. Once registered, I understand that I may utilize GMS to check the status of all grants submitted on my behalf.

I give my written consent for an American Kidney Fund agent/representative to contact me via phone/email for the purposes of completing this grant request and/or informing me of AKF related events and initiatives.

I give my written consent for a third party that American Kidney Fund may retain to contact me via phone, letter, or e-mail to conduct research related to kidney disease and the services American Kidney Fund provides, unless I previously checked the box set forth above indicating that I do not want American Kidney Fund to disclose my name or contact information.

I give my written consent for a licensed health care professional or Renal Professional (any agent/representative from the submitting organization/company) to act as my agent in connection with completing an American Kidney Fund Grant Application online, and has my permission to update personal data on my behalf.

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 that the grant provided was not used for the intended purposes (for example: not paying for health insurance with a HIPP provided grant) and/or 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.

I understand that the receipt of financial assistance from HIPP does not alter the fact that health insurance coverage represents a contractual relationship solely between myself and the insurance carrier, not between AKF and the insurance carrier. I assume all responsibilities of the contract.

I understand that as the policy holder, I am solely responsible for paying my insurance premiums in a timely manner. While HIPP makes every effort to pay premiums on or before due dates, AKF is not liable if insurance coverage is terminated.

I understand that any premium refund in connection with any health insurance policy paid by AKF from HIPP funding pool is the property of AKF and promptly must be returned to AKF.

Patient's Name (Please Print)

*Patient's Signature Date

***Signature date may not be older than 60 days from the date of submission to AKF.**

***Under 18** – Parent/Legal Guardian Signature Required

Renal Professional Confirmation

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

Renal Professional's signature _____