

List all sources of assistance available to the patient

Medicare Part D [] Yes [] No Explain benefits _____
Medicare Part D Plan Name _____ Effective Date _____
Health Insurance Coverage [] Yes [] No Explain benefits _____
State Renal Program [] Yes [] No Explain benefits _____

Requesting financial assistance for

(Please attach a list of current medications along with the monthly copay/share of cost amount or monthly cost)

[] Copayment Amount or Coinsurance
[] Annual Deductible

Total Amount Requested \$ _____ (Maximum is \$175)

Don't forget to include proof of Part D coverage.

Make check payable to:

[] Patient (or parent)
[] Other (please specify payee and address)

Name _____
Address _____ City _____ State _____ Zip _____

I ATTEST that the information provided in this application is complete and accurate to the best of my knowledge.

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Social Worker's Signature _____ Date _____

Doctor's Signature _____ Date _____

Social Worker's Name (please print) _____

Doctor's Name (please print) _____

Corporate Name _____

A photograph is not required, but we would appreciate one if available. All photos become the sole property of the American Kidney Fund.

Facility Name _____

For American Kidney Fund Office Use Only

Address _____

Amount Approved \$ _____

City _____ State _____ Zip _____

Init. _____

*Telephone _____ *Fax _____

Date _____

*E-Mail Address _____

Reason Denied _____

*Very Important

