



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

