Reset Form

Print Form

National Kidney Foundation Serving the National Capital Area
5335 Wisconsin Ave., NW, Ste. 300
Washington, DC 20015
Phone: 202.244.7900 Fax: 202.244.7405

Patient Emergency Assistance Application

(Every question must be completed by social worker.)

*** All information is held strictly confidential**

REQUIREMENTS / ELIGIBILITY

Applicant Eligibility: CKD patients residing in NKF-Maryland service area.

Categories of Need:

- ☐ Medical Equipment or Supplies
- ☐ Medications
- ☐ Transportation / Essential automobile repairs
- ☐ Food
- ☐ Dental / Vision
- ☐ Rent
- ☐ Utilities
- ☐ Phone
- ☐ Other: Considered on an individual basis.

Patient must reside in our service area

- District of Columbia
- 5 Counties in MD: Calvert, Charles, Montgomery, Prince George's and St. Mary's
- Virginia

Important: This is NOT a recurring grant! Only if another emergency situation has occurred will another grant be available after 12 months have passed. No grants are available for outstanding debts or predictable bills. Please attach supporting documentation such as a bill or notice. Thank you.

DEMOGRAPHIC INFORMATION—(Please print)

Patient's Name: _____

Address:_____ Apt # ____

City:_____

County:_____

State:_____ Zip:_____

Phone:_____

E-mail Address: _____

Age: _____

Gender: ☐ Male ☐ Female

Race: ☐ Caucasian ☐ Hispanic ☐ African American ☐ Asian ☐ Other

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced

Number of Dependent Children _____

Date of initial ESRD treatment: _____

TREATMENT INFORMATION- (Please print)

Treatment Center:_____

Social Worker:_____

Address:_____ Ste #_____

City:_____

County:_____ Phone:_____

State:_____ Zip:_____

E-mail Address:_____

CKD (Stage 5) / ESRD Treatment Modality

☐ Hemodialysis ☐ In-Center ☐ Home

☐ Peritoneal Dialysis

☐ Transplant ☐

Patient's Name: _____

INCOME & INSURANCE INFORMATION

Amount of Monthly Income: (combined income for patient, spouse and dependent children)

☐ $0-$499 ☐ $500-$999 ☐ $1,000-$1,499 ☐ $1,500-$1,999 ☐ $2,000 & above

Must indicate coverage available to patient and explain benefits as related to need:

☐ Medicare: _____

☐ Medicaid: _____

☐ Health Insurance Coverage: _____

☐ State Renal Program: _____

REQUEST FOR ASSISTANCE- (This must be an urgent/emergency situation.)

Explanation of Need: (continue on separate page if more space is needed).

Cost: $ _____ (Documentation must be attached.)

Resources Contacted and Response: (Other resources, if available, must be contacted & documented.)

1.

2.

3.

Amount Requested: $_____(not to exceed $200) Can be divided into multiple requests on this one form.

Check Payable to: _____

Mail Check to: _____

_____

☐Patient has been encouraged to repay funds so that others may be assisted.

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

Patient (Must sign) Date

Social Worker (Must sign) Date

For Internal Use Only:	CNSW:_____	NKF:_____
☐ Approved ☐ Denied Amount: _____	Date: _____	Date: _____