FINANCIAL ASSISTANCE APPLICATION

Please fill out all information completely. If something does not apply, write N/A.

PATIENT / APPLICANT INFORMATION		
Name:		
Date of Birth:	SSN:	Phone:
Current Address:		
City:	State:	ZIP Code:
Marital Status:	Spouses Name?	
Household Dependents (list names & ages):		

SCREENING INFORMATION	
Have you received assistance from MCKF in the past year?	
If yes, please provide the date and the amount of assistance provided in the spaces below:	
Date:	Amount:

TYPE OF ASSISTANCE REQUESTED		
Food	Dietary Supplements	Rent / Mortgage
Transportation	Utilities	Medical Equipment
Eyeglasses	Medical Services	Family Emergency
Other (please specify):		
Amount Requested:		
Check Payable To: **Vendor Name – can not be made payable to applicant*		

SOCIAL WORKER'S INFORMATION	
Dialysis Unit:	
Social Workers Name:	
Social Worker's Phone #:	Social Worker's Email:
Social Workers Initials: *I attest that the information on this form is complete & accurate to the best of my knowledge*	
Social Workers Narrative *(Provide a complete explanation of the circumstances which require this financial assistance. Attach additional pages if needed)*	

FINANCIAL INFORMATION			
ASSETS		**LIABILITIES**	
Bank: Checking Account	$	Loans	$
Bank: Savings Account	$	Other Debts	$
Home – Assessed Value:	$		
Auto (Make & Year):	$		
Other:	$		
MONTHLY HOUSEHOLD INCOME		**MONTHLY HOUSEHOLD EXPENSES**	
Employer:		Rent / Mortgage / Taxes:	$
Spouse's Employer:		Food:	$
Take-Home Pay:	$	Telephone:	$
Spouses Take-Home Pay:	$	Cell Phone:	$
Social Security:	$	Electricity / Water / Gas:	$
SSI / SSDI:	$	Cable TV:	$
AFDC:	$	Internet:	$
Retirement Income:	$	Medical Insurance:	$
Veteran's Benefits:	$	Auto Payments / Gasoline:	$
Food Stamps:	$	Auto Insurance:	$
Child Support:	$	Patient Medications:	$
Other:	$	Other Insurance:	$
		Loans:	$
		Credit Cards:	S
		Transport (treatment related):	$
		Other:	$
TOTAL MONTHLY INCOME:	**$**	**TOTAL MONTHLY EXPENSES:**	$

ADDITIONAL ORGANIZATIONS WITH WHOM THE APPLICANT HAS APPLIED FOR ASSISTANCE	
ORGANIZATION	**RESULT**
Personal Family Resources	
Brother's Keeper	
Interfaith	
Salvation Army	
Community Action Agency	
Other (please specify)	

APPLICANT / PATIENT AGREEMENT

Applicants Signature: Date:

By submitting this application, the applicant guarantees its' accuracy and truth with the intent that it be relied upon by the Marion County Kidney Association in considering assistance to the undersigned. The applicant also agrees that the information in this application may be verified or that additional supporting documentation may be requested.

MCKF USE ONLY		
Date Received:	Approved:	Denied:
Reference #:	Amount: $	
Payee:		

Advisory Board Members Signature: Date:

Please have your Social Worker FAX the completed form to: 866-671-7131