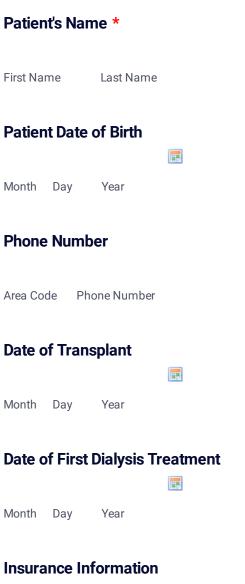


## **Patient Financial Profile**

CONFIDENTIAL



Private Insurance

AHCCCS.

Medicare

VA Coverage

No Coverage



#### **Insurance Carrier Name**

**Insurance Expiration Date** 

Month Day Year

#### **Treatment Facility**

Address

Street Address

Street Address Line 2

City State / Province

Postal / Zip Code

#### How long at current address?

#### Home is:

Rented Owned Name and address of Landlord (rented) or Leinholder (own)

#### **Marital Status**

#### **Number of Dependents**

#### Household is less than 400% Federal Poverty Level (see chart below)

Yes No

Household size (number living there) / 400% Federal Poverty Guidelines

1	2	3	4	5	6	7	8
\$47,520	\$64,080	\$80,640	\$97,200	\$113,760	\$130,320	\$146,920	\$163,560

# Demographic information is often required to obtain grant funding for patient programs.

This is optional, but greatly appreciated.

#### Patient Ethnicity (Please choose one)

Is patient of Hispanic descent? (Please choose one)



#### Patient is an enrolled member of the following tribal community, village, reservation or nation:

Please select all that apply

#### Date



#### **Unit Representative Name**

First Name Last Name

#### Position

Date

Duto			
Month	Day	Year	





## INFORMATION REQUIRED TO DOCUMENT THE USE OF FUNDS ALLOCATED FOR KIDNEY PATIENT PRESCRIPTIONS

NKF AZ Medications Program is mandatory generic. Brand name medications will not be covered when there is a generic available.

#### **Patient Name**

First Name Last Name

#### **Date of Birth**

Month Day Year

#### **Patient Security Number**

#### Referred by(Treatment Center Staff)

First Name Last Name

#### **Treatment Facility**

#### **Current Patient Financial Form on file with NKF AZ?**

Yes

No

Submiting with this form

#### **Date of Transplant**

Month Day Year





#### **Other Resources**

	Applied	Pending	Accepted	Denied				
Secondary Ins								
AHCCCS								
Date Applied for other resources								

Month Day Year

### **Pharmacy Preference**

