National Kidney Foundation™
of Arizona

Patient Financial Profile

CONFIDENTIAL

Patient's Name *

First Name Last Name

Patient Date of Birth

Month Day Year

Phone Number

Area Code Phone Number

Date of Transplant

Month Day Year

Date of First Dialysis Treatment

Month Day Year

Insurance Information

- ☐ 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

Month Day Year

Unit Representative Name

First Name Last Name

Position

Date

Month Day Year

Submit

National Kidney Foundation™
of Arizona

Transportation assistance application form

Transportation Assistance Requested

Date of Request

Month Day Year

Patient Name

First Name Last Name

Current Patient Financial Profile:

- ◯ On File (Must be dated within 6 months of request)
- ◯ New, being submitted with this request

Social Worker Name

Description of Financial Need:

Description of Travel Need:

Transportation Provider

Miles

Trip Date

Month Day Year

Trip Cost

Trip Description

Trip Origin

Trip Destination

Submit

National Kidney Foundation™
of Arizona

Car Payment/ Repair Assistance Consent

Applicant Name

First Name Last Name

Loan or Repair Company

Loan Number

Company Phone

Area Code Phone Number

Referred by (Treatment Center Staff)

Facility Name

Total amount of bill

Amount of request from NKF AZ

I certify that I am financially unable to pay my car payment/ repair bill, that I have exhausted all other sources of help with the attached bill, and that the above information is true and correct to the best of my knowledge.

I hereby consent to and authorize the National Kidney Foundation of Arizona to access any information from the loan/ repair company concerning my payment history, delinquencies, outstanding amounts owed, required deposits, and other related information, and to use such information only in connection with this application for assistance.

Date

Month Day Year

Relationship to applicant

Date

Month Day Year

Submit