NATIONAL KIDNEY FOUNDATION OF ARIZONA

360 East Coronado Road, Suite 180; Phoenix, Arizona 85004; (602) 840-1644; FAX (602) 845-7968

CONFIDENTIAL
Patient Financial Statement

Patient's Last Name	**First**	**Middle**	**Date of Birth**	**Spouse's Name**
Mailing Address				**Phone**
City	**State**	**Zip**	**How Long have you lived at this address?**	

Household Members **Please list <u>all</u> individuals living at this address**	**Date of Birth**	**Relationship to You (or enter 'Self')**	**Employed? (Y or N)**	**Total Monthly Gross Income (Include SSI, Food Stamps, and other.)**
1				
2				
3				
4				
5				
6				
7				

Do you rent or own your current residence?

☐ Rent ☐ Own

Total Household Monthly Income:

Monthly Household Expenses

Rent or Mortgage	$_____
Food	$_____
Utilities	
Phone	$_____
Gas	$_____
Electric	$_____
Water	$_____
Auto	
Payment	$_____
Gas & Oil	$_____
Insurance	$_____
Medical	
Doctor & Hospital	$_____
Hospital	$_____
Medicines	$_____
Insurance	
Life	$_____
Medical	$_____
Credit/Charge Card payments	$_____
Other monthly payments (list)	$_____
TOTAL MONTHLY EXPENSES	$_____

Bank Assets:

Checking balance $_____

Savings balance $_____

Has the patient ever served on active duty in the U.S. Armed Forces, Military Reserves, or National Guard?

☐ Yes ☐ No

Health Insurance Information:

Provider: _____

Policy Number: _____

Group Number: _____

AHCCCS: _____

Expiration date: _____

VA Coverage: ☐ Yes ☐ No

Is Household less than 400% Federal Poverty Level? ☐ Yes ☐ No
See chart below

Household size	1	2	3	4	5	6	7	8
400% 2023 Federal Poverty Guidelines	$58,320	$78,880	$99,440	$120,000	$140,560	$161,120	$181,680	$202,240

By signing below, you acknowledge that the above information is true and correct.
False statements could disqualify the patient for this or future assistance from National Kidney Foundation of Arizona.

_____
Patient Signature

_____
Date

_____
Clinic Representative Signature

_____
Please print name (Clinic Representative)

_____
Clinic Name

_____
Date

Revised: February 2024