NATIONAL KIDNEY FOUNDATION® of Arizona

RENT ASSISTANCE

PATIENT APPLICATION & CONSENT

Please read the information below before requesting assistance from the National Kidney Foundation of Arizona (NKF AZ).

Evictions can move quickly, so it is important that you provide all the required information and documents. If any of the required documents or information are missing or incomplete, we will not be able to process your application.

Be prepared to respond quickly to requests for additional information. Applications will be closed after 2 weeks of inactivity (no response from the applicant, social worker/clinic representative, or property owner/manager).

PROGRAM LIMITATIONS

Assistance is only for base rent.
NKF AZ cannot pay:

- Any other fees that are included in the lease, including taxes, trash service, utilities, pet fees, or any other amenities
- Late fees, court fees, attorney fees, or other penalties

Rent Eviction Prevention assistance is for those who have received a "5 Day" or eviction notice. NKF AZ can only provide assistance if our payment prevents the eviction.

This is a one-time assistance program for either rent or utilities. If your application is approved, you will not be eligible for further rent/utility assistance from NKF AZ.

Property managers/owners require full payment, including all late fees to prevent eviction.

- You must be prepared to immediately pay any fees not covered by NKF AZ, if you are approved for this assistance.
- NKF AZ contacts the property managers/owners to confirm that the balance NKF AZ cannot cover has been paid.

NOTIFICATION OF APPROVAL OR DENIAL

If approved for this assistance, NKF AZ will send a copy of the approval letter to your social worker/clinic representative and the property owner/manager. Your social worker/clinic representative will provide you with a copy of the letter.

If your application is not approved, your social worker/clinic representative will be notified by email.

REQUIRED DOCUMENTATION

Please provide the following required documents to the social worker or clinic representative who is submitting the application for you:

- This completed and signed consent form.

- NKF AZ Financial Statement
  - Must include information on all individuals residing in the household
  - Must be signed by the patient and the social worker (or other clinic representative) who is submitting the application.
  - Be sure the form is complete and accurate. False statements may disqualify you from this and future assistance from NKF AZ.
- Current lease agreement
  - The lease must be a formal, signed lease. Hand-written, verbal, and email agreements are not accepted.
    - Sub-let agreements are only accepted if they are a formal written and signed lease agreement.
  - If the patient is not listed on the lease, additional verification that the patient is living at the address is required. Acceptable verification includes:
    - A copy of the patient's Arizona State ID that lists the address
    - A bill in the patient's name that has been sent to the address (no "junk" mail)
    - Some other formal document mailed to the patient at the address
- Current rent statement showing the most recent 3-4 months of charges and payments to your rent account
- Eviction notice or "5-day Notice", if applicable.
  - "5-day" notices are only valid if they include the amount the tenant owes and a statement informing the tenant they have five calendar days to pay the amount owed.
  - Eviction notices are only valid if delivered to the tenant in person either via hand delivery, posted to a secure and visible position near the entrance of the rented property, or sent to the tenant via certified mail.

OTHER AGENCIES CONTACTED

NKF AZ is an agency of last resort, and we require that assistance has been requested from at least two other agencies before requesting assistance from NKF AZ.

What other agencies have you contacted for assistance?

First agency contacted for assistance:	
Date you contacted them:	
Their decision/response?	

Second agency contacted for assistance:	
Date you contacted them:	
Their decision/response?	

Please describe how your household got into this financial crisis.

How does your household plan to avoid the need for future rent assistance?

NATIONAL KIDNEY FOUNDATION® of Arizona

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PATIENT APPLICATION & CONSENT

Applicant's Name _____

Address _____

_____

Property Owner or
Rental Company _____

Owner/Company phone # _____

Owner/Company email _____

Applicant's Rent Account Number _____

Referred by _____
(Social Worker or other referring clinical staff)

Dialysis Unit/Transplant Center _____

Total Amount owed by applicant _____

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

I acknowledge that I have read and understood the information above regarding the required documents and information, and if approved for this assistance, I will need to be able to pay all fees not covered by NKF AZ at the time of the approval.

I hereby consent to and authorize the National Kidney Foundation of Arizona to access any information from the property owner/manager 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.

Applicant's Signature _____ Date _____

Co-Applicant's Signature _____ Date _____

NATIONAL KIDNEY FOUNDATION OF ARIZONA

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

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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 (work income, SSI, Food Stamps, and ALL other income/assistance)**
1				
2				
3				
4				
5				
6				
7				
		Total Household Monthly Income:		

Monthly Household Expenses

Rent or Mortgage	$_____
Food	$_____
Utilities	
Phone	$_____
Gas	$_____
Electric	$_____
Water	$_____
Auto	
Payment	$_____
Gas & Oil	$_____
Insurance	$_____
Medical	
Doctor	$_____
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

Do you rent or own your current residence?

☐ Rent ☐ Own

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: December 2024