NATIONAL KIDNEY FOUNDATION of Arizona

UTILITY ASSISTANCE

PATIENT APPLICATION & CONSENT

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

Utility shutoffs 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

Utility companies offer a variety of payment plans. You must attempt to set up payment arrangements with the utility company before applying for NKF AZ utility assistance.

- NKF AZ confirms whether there has been an attempt to set up payment arrangements. If not, the application will be declined.

Assistance is only for one utility (water, electricity, or gas).

Assistance can cover a maximum of $800 for up to two months in arrears.

For example: If you are 3 months behind on your electricity bill, NKF AZ can only pay 2 months of that bill for *up to* $800. You would be responsible for paying for the remaining one month.

NKF AZ cannot pay:

- Reconnect fees, late fees, or any other penalties.
- When our payment does not prevent the utility shutoff.
- 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 utility company to confirm that the balance NKF AZ cannot cover has been paid.

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.

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 utility company. 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 utility bill
  - If the bill is not in the patient's name, 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

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 utility assistance?

Applicant's Name ____

Address ____

____

Utility Company ____

Utility Company phone # ____

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Applicant's Utility 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 utility 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 from the above named utility company, and for this utility company to release, the information concerning my payment history, delinquencies, outstanding amounts owed, required deposits, usage history, 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 __________________

360 East Coronado Road, #180, Phoenix, AZ 85004
(Phoenix) 602-840-1644 (Toll free) 1-877-587-1357
Fax 602-845-7968

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 (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