



UTILITY ASSISTANCE CONSENT FORM

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 information is 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 two 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 available for one utility (water, electricity, or gas).
- Assistance can cover up to two months in arrears for a maximum total award of \$800.
 - For example: If you are three months behind on your electricity bill, NKF AZ can only pay two 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 pay any fees or remaining balance not covered by NKF AZ, whether due immediately or through a payment arrangement with the utility company.

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 and will provide you with that information.

REQUIRED DOCUMENTATION

Please provide the following required documents to the social worker/clinic representative who is submitting the application on your behalf:

- 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/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); or
 - Some other formal document mailed to the patient at the address.

OTHER AGENCIES CONTACTED

Before requesting assistance from NKF AZ, you are expected to explore at least two other agencies or resources that may be able to assist you.

This helps ensure that NKF AZ assistance remains available for situations where other resources are not available, accessible, or sufficient to meet your needs.

What other agencies or resources have you contacted for assistance?

First agency contacted for assistance:	
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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 Number _____

Applicant's Utility _____

Utility Account Number _____

Referred by _____
(social worker/clinic representative)

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. This consent and authorization shall expire following NKF AZ's review of my customer account information for qualification of financial assistance.

Applicant's Signature _____ Date _____

Social worker/clinic representative Signature _____

Date _____

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