National Kidney Foundation™ of Louisiana

Mail to: NKF of Louisiana—Crisis Fund
8200 Hampson Street, Suite 425 * New Orleans, LA 70118
Contact: 504-861-4500 * 800-462-3694 * www.kidneyla.org
PLEASE MAIL (NO DEADLINE DATE) * DO NOT FAX**

CRISIS INTERVENTION GRANT APPLICATION

Part A: (*To Be Completed by the Patient*) Date: _____

Name: First **Middle Initial** **Last**

Street Address/Apt. #

City **State** **Zip**

Primary Telephone (with area code) **Secondary Telephone**

Insurance Benefits

Medicare: Yes ☐ No ☐
Medicaid: Yes ☐ No ☐
Pending ☐ Spend-Down ☐
Insurance: Yes ☐ No ☐
Part D: Yes ☐ No ☐
AARP: Yes ☐ No ☐
HMO/PPO/Private: Yes ☐ No ☐

Date of Birth **Gender: M or F** **If applicant is minor-please list Parent/Guardian's Name**

 # people in your household; who they are; list ages of dependents (for example: spouse, 2 children ages 3 and 12, friend = total of

Specify the type of assistance being requested: (check one)

- ☐ Medication
- ☐ Rent/Mortgage
- ☐ Food/Diet suppl.
- ☐ Other _____
- ☐ Transportation
- ☐ Utilities
- ☐ BP/Glucose Monitor

Checks cannot be made payable to applicant; write in name of vendor such as Walgreens, Cleco, AT& T, Entergy, etc.

Check Payable to: _____

Amount Requested: ($75 maximum) _____

Monthly Income: **FOR EVERYONE LIVING IN HOUSE**

Patient's Employer Name _____
Spouse's Employer Name _____
Patient's Take Home Pay ..... $_____
Spouse's Take Home Pay ..... $_____
Other Residents Income/Contribution ..... $_____
Social Security for self __spouse ___child___ .... $ _____
SSI/SSDI for self __spouse ___child___ .... $ _____
AFDC/Public Assistance ..... $ _____
Retirement/Pension Income ..... $ _____
Veteran's Benefits ..... $ _____
Child Support/Alimony ..... $ _____
Food Stamps ..... $ _____
Other _____ $ _____
Other _____ $ _____
TOTAL MONTHLY INCOME $ _____

Office Use Only: Date Received: _____
Approved ☐ Check# _____ Amount $_____
Payee: _____
Pending ☐ Denied ☐ Letter Mailed: _____

Monthly Expenses: **For Yourself and/or Household**

Mortgage ..... $ _____
Rent/ or your contribution ..... $ _____
Flood/Homeowners Insurance *(not in mortgage)* $ _____
Renter's Insurance ..... $ _____
Electric/Gas ..... $ _____
Water ..... $ _____
Phone .....**($40 maximum)**..... $ _____
Cell Phone .....**($75 maximum)**..... $ _____
Cable T.V. .....**($60 maximum)**..... $ _____
Auto Payment (s) (# of vehicles _____)... $ _____
Auto Insurance ..... $ _____
Gasoline (for treatment/Dr. appointments) . $ _____
Food (include food stamp & out-of-pocket).. $ _____
Treatment related Transportation ..... $ _____
I use the (bus ____ taxi ____ Medicaid Service ____ Friend _____)
Patient Medication Co-Pays ..... $ _____
Spouse/Dependents' Medications ..... $_____
Hospital/Dr. payments ..... $ _____
Spouse/Dependents' Medical payments ..... $ _____
Health Insurance (Private or Medicare) ..... $ _____
Life Insurance ..... $ _____
Other Ins. (Dental __ Burial __ or _____) $ _____
College Loans or School Tuition ..... $ _____
Loans (___SBA ___ Bank or _____)$ _____
Credit Card Payments ..... $ _____
Other Expenses (Please list _____
_____) $ _____

TOTAL MONTHLY EXPENSES $ _____

Applicant Name: _____

Part B: <u>These questions should be answered by the patient</u> (Please print legible—if we are not able to read this section, it can delay the processing of your application.) All questions must be answered. You may write on the back if additional space is needed.

1) Please explain the crisis or emergency that has caused a need for financial assistance. This explanation should give details to the fact that was not a planned monthly expense, and the funds were used for this specific emergency. (**PLEASE PROVIDE SUPPORT DOCUMENTS AS PROOF OF THIS EMERGENCY**) The back of paper may be used for additional space.

2) Explain how this emergency grant will solve the immediate crisis and how you will solve this situation in the near future.

3) Is this a one-time need? ❑ Yes ❑ No? If the answer is no and we provide assistance, what plans are being made to ensure that this need will be met in the coming months? Please be specific.

4) Will you be placed at medical risk if you do not receive this grant ❑ Yes ❑ No?
5) If this request is for past due balances, has an attempt been made to set up a payment plan ❑ Yes ❑ No?
6) If this request is to avoid utility shut-off, do you have the remainder of the balance ❑ Yes ❑ No?
   Please explain how you will get the remaining funds.

7) If this request is for food, have you contacted Angel Food Ministries or the Food Banks ❑ Yes ❑ No?
   Please explain the final outcome of those attempts to receive food?

8) If this request is for medications (over the counter can be included) or nutritional supplements, has an attempt been made to obtain samples ❑ Yes ❑ No? Has an attempt been made to prescription assistance programs ❑ Yes ❑ No?
   Please explain the final outcomes of those attempts.

9) You may provide other important information for consideration of a crisis intervention grant if you desire. (use back of paper)

10) Have you **<u>ever</u>** received grants/funds from the National Kidney Foundation or NKF of Louisiana in the past 12 months?
   ❑ Yes ❑ No? If yes, please list the dates and amounts received.

I certify that I have provided complete and truthful information in Part A and B of this application. I understand the NKF of Louisiana may <u>request additional documentation</u> and that if I fail to provide such information, my application will be withdrawn. I also understand that if the application is denied or withdrawn, I can not reapply before one year from the date of such denial or withdrawal.

_____ _____
Applicant Signature Date

* Grants are for a maximum of $75.00. You may apply for a grant one time within a six month period. Please remember that a crisis is defined as an emergency situation which can be resolved with a one time grant. NKF of LA is not required to provide you with emergency funds for on-going financial difficulties every six months.

*** **The following documents must be included with your application, for the <u>following vendor</u> payments:**

Rent: A copy of a current lease which shows your name, # of tenants, rent amount, and address of property.
Mortgage: A recent copy of mortgage statement with the property address.
Utilities: A copy of bill or disconnect notice which has a due date falling after the day of the month in which application was submitted. If the bill is in a name other than your spouse—please attach an explanation.
Medications: A copy of previous receipt for medications or statement from pharmacy listing prices.
Transportation: A statement from transportation /taxi company indicating the round-trip fee.
BP/Glucose Monitor: A copy of px from doctor for medical equipment and invoice from company where it will be purchased.
Food/Diet Supplements: A statement from the clinic's dietician, social worker or doctor explaining the need for these items.
Other: Please submit supporting invoices or documents from this vendor.

Applicant Name: _____

Part C: To be completed by Social Worker, Clinic Administrator, or Renal Physician:

_____

Name of Person Completing Section C

_____

Facility Name Physician's Name

_____

Mailing Address of Facility

_____ _____ _____

City State Zip

_____ _____

Facility Primary Telephone (with area code) Days & Hours of Operation

_____ _____

Social Worker's Name email address

_____ _____ _____

Telephone /Extension (with area code) Fax Number Days & Hours at this Facility

Medical Information:

Date patient was diagnosed with ESRD: _____ 1st Tx Date at present facility: _____

Which treatment modality is patient receiving at present time:

❑ Hemodialysis ❑ Peritoneal Dialysis ❑ In-Home Hemodialysis ❑ Nocturnal Hemodialysis ❑ Transplant Recipient

What are other medical conditions, if any: _____

Other Resources Explored:

The Crisis Intervention Fund is a "last resort" option for the patient. Which of the following resources have been explored and exhausted? Please list the amount received and dates for past 12 months or if denied, list the date and reason for denial.

❑ American Kidney Fund _____

❑ Prescription Assistance Programs _____

❑ Food Banks _____

❑ Church/Family/Friends _____

Have you applied for a NKF Crisis Intervention Fund for this patient in the past? ❑ Yes ❑ No?

If yes, please list the date, vendor, and amount or if denied please list the date of application:

Received: _____

Denied: _____

❑ By placing a check mark in this box, you are verifying that the Insurance Benefit information completed in Part A by the patient, is accurate and true to your knowledge.

I certify that this patient is presently receiving treatment and has requested an application for financial assistance. I have explored and explained other available resources to this patient.

_____ _____

Signature of Person Certifying this Page Date of Signature

**** PLEASE DO NOT FAX ** PLEASE DO NOT FAX ** PLEASE DO NOT FAX ****