National Kidney Foundation® of Michigan

Luann Scheppelmann-Eib Patient Emergency Fund Application

PATIENT TO COMPLETE THIS SECTION

Name: ______________________________

Address: ______________________________

City: ______________________________

Zip: ____________ Date of Birth: ________________

Number of Dependents: ____________________

Social Security #: ______________________________

County: ______________________________

Email: ______________________________

Phone Number: (_____) ____________________

MONTHLY HOUSEHOLD INCOME:

Yours: $ ________ Source ____________________

Other: $ ________ Source ____________________

(All others in household)

Total: $ ________

Number of people dependent on household income: _____

MONTHLY EXPENSES:

Housing (rent, mortgage, property taxes)	$_________
Utilities (gas, electric, phone, water, etc.) *actual monthly bill*	$_________
Insurance (health, life, auto, home)	$_________
Food	$_________
Transportation (gasoline, taxi fare, bus)	$_________
Loans (auto, credit card payments, etc.)	$_________
Clothing	$_________
Medication expenses	$_________
Other monthly expenses (specify)	$_________
Total:	$ _________

HOUSEHOLD ASSETS:

Checking Account: $_________

Bank Name: ____________________

Savings Account: $_________

Bank Name: ____________________

Home (Assessed Value): $_________

Stocks & Bonds: $_________

Automobile:

Year/Make: ____________________

HOUSEHOLD LIABILITIES: (Loans/Debts)

Bank Name: ____________________ $_________

Bank Name: ____________________ $_________

Others (Specify): ________________ $_________

________________ $_________

Amount Requested: ______________________________

Please specify your need for which funds are to be used: ______________________________

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***Vendor Name for Check:** ______________________________ ***OR* Gift Card** *(circle one)*: **Meijer** **Kroger**

In submitting this application, the patient guarantees its truth and accuracy. The patient also agrees that the information in this application may be verified. Please attach receipts or additional documentation.

Signature: ______________________________ Date: ____________________

Updated: 1/16/2018

Return completed application to the:
National Kidney Foundation of Michigan | 1169 Oak Valley Drive | Ann Arbor, MI 48108.
If you have any questions call 1.800.482.1455 or 734.222.9800. Fax number is 734.222.9801.
www.nkfm.org

Luann Scheppelmann-Eib
Patient Emergency Fund Application (cont.)

SOCIAL WORKER/DOCTOR'S OFFICE STAFF

Please review this patient's application for benefits from the NKFM's Patient Emergency Fund and provide us with the following additional information. Your completion of this form in its entirety will facilitate prompt consideration of this request.

Modality

- ❒ Transplant
- ❒ Hemodialysis
- ❒ CAPD
- ❒ CCPD
- ❒ Other ___________

Health Insurance
(check all that applies)

- ❒ Medicare
- ❒ Blue Cross
- ❒ Medicaid
- ❒ Special Health Care Services
- ❒ HMO Specify ___________________
- ❒ Other Specify ____________________

Prescription Coverage

- ❒ Medicaid (Spend-down $ ___________)
- ❒ Deductible per prescription $ ________
- ❒ Reimbursement for prescriptions ____ %
- ❒ No Prescription Coverage

Because of the limited funds available, the National Kidney Foundation of Michigan's Patient Emergency Fund is to be considered a "last resort" when alternate sources of assistance are not available. Please indicate whether the patient is eligible for the following resources and whether they have been considered as sources of funding for the current need.

Resource	Yes	No	Explain
Medicare			
Medicaid			
Special Health Care Services			
State Vocational Rehabilitation			
Private Health Insurance			
Veteran's Benefits			
Church/Other charitable organizaiton			
Other Resources			

Please provide us with your comments and recommendations regarding this patient's need for financial assistance.

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Social Workers Name: ____

Facility Name: _________________________________ Phone: (_____) ________________

Facility Address: ____

Updated: 1/16/2018