



Application for any TKF Grant **Date of Application**_____

Name_____

Permanent Address – Number and Street_____

City Zip Code County Telephone Number

Birthdate: Month_____ Day_____ Year_____ Race_____ Sex_____

Marital Status: Married___ Single___ Separated___ Divorced___ Widowed_____

Veteran: Yes_____ No_____ VA Benefits Applied for? Yes_____ No_____

No. of Dependents (Including Self):_____ No. of other people living in home:_____

LIST PERSONS LIVING IN HOME

NAME	AGE	RELATIONSHIP	EMPLOYED

Center where patient receives dialysis or Transplant_____

Present Status: In-Center Dialysis_____ Home Patient_____ Transplant Patient_____

HEMO_____

CAPD_____

CCPD_____

Social Worker at Center_____ Phone Number_____

ASSIGNMENT OF PATIENT NUMBER BY TKF

Chronic Renal Disease Financial Inventory

Patient Name			Dialysis Center			Date 1 st Dialysis		
Pharmacy Name			Pharmacy Address			Pharmacy Phone		
Applied			Approved			Terminated		
Yes	No	Date	Yes	No	Date	Yes	No	Number
A. Medicare								
B. Medicaid								
C. Medically Needy								
D. Private Medical Insurance			Company			Policy No.		
			Drug Benefits?			Benefits Remaining		

Is this a ONE TIME REQUEST? _____ RECURRING REQUEST? _____

INCOME

DEDUCTIONS

	Net Mo. Amount	Total Monthly Income	Total A (Yearly Income)		Monthly	Yearly
A. Income Sources				A. Rent or Mortgage		
				B. Utilities		
				C. Prems on Health Ins.		
				D. Other Expenses (Itemized).		
TOTAL B						
B. Stocks & Bonds Savings						
ASSETS						
C. Luxury Personal Property/Non-income Producing Real Estate		Value	TOTAL C	E. Actual Payment being made on Medical Bills		

II. Total Deductions (A through E.)

Adjusted Resources (Subtract Total II from Total A)

Date: _____ Social Workers Signature _____

Patients Signature _____ I certify that the above is true to the best of my knowledge.

**Authorization for release of Medical and Financial Information
Tennessee Kidney Foundation – TKF Grant**

I, undersigned, do agree to authorize the release of all previous medical records to the Tennessee Kidney Foundation (TKF) Patient Services Committee Chair or the approved Renal Center. I also authorize the TKF Patient Services Committee Chair to review my financial records at any institution, agency, corporation or any other establishment which has or might have knowledge of my financial assets or circumstance during the application procedure and while participating in the program.

Further, if accepted, it is understood that the program covers only those costs for medications, transportation or a one time utility payment. Payment for care will be provided as long as current appropriations are available. Other payments may cease at any time, in accordance with policies developed at the TKF. I give permission for the unit social worker to release my demographic and medical information to the TKF.

Applicant's Signature

Parent or Guardian's Signature if applicant is under 18

Date

Witnessed by

Title or Address



CHANGE SHEET

This is to inform you that _____

Died on _____

Was Transplanted on _____ **at** _____

Began Home Dialysis: _____ **Hemodialysis;** _____ **CAPD:** _____ **CCPD**

Stopped Dialysis on _____ **because** _____

Moved ; New Address: _____

Was transferred to _____

Wishes to change pharmacies

From _____

TO: _____

Address of Pharmacy _____

Phone of Pharmacy _____