

Kidney Transplant/Dialysis Association, Inc.

P.O. Box 51362 GMF • Boston, MA 02205-1362 • (781) 641-4000

Application for Financial Assistance

Instructions: Please answer all questions. Incomplete applications will not be processed. Since in nearly all cases we pay directly to creditors, please submit estimates, bills, or receipts. Supply the names of creditors who are to be paid or reimbursed. Return completed application to your Social Worker, who will fill out the last section. Ask your Social Worker to mail three (3) copies of the application form and all supporting documents to the address above. **PLEASE PRINT.**

DATE OF APPLICATION: _____ AMOUNT OF AID REQUESTED: \$ _____

PURPOSE: _____

Applicant's Name: _____ Age: _____ Marital Status:
Address: _____ How many in household Single
City: _____ State: _____ Zip: _____ (including applicant)? _____ Married
Telephone: (____) _____ Separated
 Divorced
 Widowed

Are you a: Dialysis patient Transplant recipient Kidney donor Parent of patient
Name of Hospital or Center: _____
Medical Insurance: Medicare Medicaid Blue Cross/Blue Shield Other (specify) _____

Are you employed? Yes—Occupation: _____ No Retired Student Other
If employed, Name of Employer: _____ No. of Years: _____
Employer's Address: _____

Principal Wage Earner in Household: Applicant Spouse Other (specify) : _____

If Principal Wage Earner is NOT the applicant, please complete the items below:
Relationship to Applicant: _____
Name of Employer: _____
Address of Employer: _____
Monthly Income (before taxes): \$ _____

MONTHLY INCOME BEFORE TAXES

Wages \$ _____
Souse's Wages \$ _____
Wages of Others \$ _____
Disability \$ _____
Social Security \$ _____
Welfare \$ _____
SSI \$ _____
Medicaid \$ _____
Pension \$ _____
Veteran's benefits \$ _____
AFDC \$ _____
Other Income \$ _____
_____ \$ _____
_____ \$ _____
TOTAL MONTHLY INCOME
BEFORE TAXES \$ _____

ASSETS

Do you Own or Rent your own home?
Checking \$ _____
Savings \$ _____
Stocks and Bonds \$ _____
Other Assets \$ _____
_____ \$ _____
_____ \$ _____
TOTAL ASSETS\$ _____

MONTHLY EXPENSES

Rent or Mortgage \$ _____
Is heat included? Yes No
Food \$ _____
Utilities: Phone \$ _____
Gas/Oil \$ _____
Electricity \$ _____
Water \$ _____
Property Taxes \$ _____
Transportation
Auto Payment \$ _____
Other_____ \$ _____
Monthly Medical Expenses:
Doctors &
Dentists \$ _____
Hospital Pmts \$ _____
Medications \$ _____
Insurance:
Medical \$ _____
Life \$ _____
Auto \$ _____
Other_____ \$ _____
Charge Accts. \$ _____
_____ \$ _____
_____ \$ _____
Loans \$ _____
Other _____ \$ _____
_____ \$ _____
TOTAL MONTHLY
EXPENSES \$ _____

To be filled out by Social Worker

Your Name: _____ Name of Center: _____

Address: _____

E-mail address: _____ Telephone: (_____) _____

I have reviewed this application for financial assistance and recommend that _____
(Name of Applicant)

be awarded \$ _____ made payable to _____

Purpose of grant (brief history of patient/recipient and discussion of financial need): _____

Signature: _____ Date: _____

PLEASE DON'T FORGET TO MAIL THREE (3) COPIES OF EVERYTHING!