The Bridge to Transplant Award Application

Fax to: 866-671-7131

Name:	
Address:	
Phone:	
SSN:	**DOB:**
Marital Status:	
Support System:	
Dialysis Clinic:	**Nephrologist:**
Dialysis Social Worker (if applicable):	
What is your Kidney Disease:	
☐ Hypertension	☐ Cancer
☐ Glomerulonephritis	☐ Other Urologic Reason
☐ Diabetes	☐ Unknown
☐ Genetic/Congenital Kidney Disease (PKD)	☐ Other
What is your current status:	
☐ Dialysis Patient – Never Transplanted	☐ Kidney Donor
☐ Dialysis Patient – Post Transplant	☐ CKD Patient – Stage IV
Which Transplant Program are you in evaluation with:	
Please attach letter from your Transplant Program stating your Financial Proof of Affordability that you are required to provide.	
What efforts, if any, have you made to raise the funds needed for your Financial Proof of Affordability:	
What is the amount of funds that you have currently raised:	
What is your Medical Insurance:	
☐ Medicare	☐ Primary ☐ Secondary
☐ Medicare Advantage	
☐ Medigap/Medicare Supplement	☐ Secondary
☐ Commercial	☐ Primary ☐ Secondary
☐ COBRA	☐ Primary ☐ Secondary
☐ Florida Medicaid	☐ Primary ☐ Secondary
☐ Veterans Administration	☐ Primary ☐ Secondary

How is your insurance premium paid:	
☐ I pay my own premium.	
☐ The American Kidney Fund pays my premium.	
If the American Kidney Fund assists you, which Medical Insurance premium(s) are they paying for:	
What is your Prescription Plan:	
Employment:	
Are you employed? ☐ Yes ☐ No	If not, when did you last work?

Patient Financial Information
❖ Please note that the Marion County Kidney Foundation reserves the right to request proof of finances for the purpose of determining eligibility for award.
❖ This award is designed to help CKD and ESRD Patients who are in need of financial assistance for their Financial Proof of Affordability for their Transplant Program.

Assets		**Liabilities**	
Bank – Checking	$	Loans	$
Bank - Savings	$		
Home Assessed Value	$		
Stocks/Bonds	$	Other Debts	$
Other	$		
Auto(s) – Year/Make			
Monthly Household Income		**Monthly Household Expenses**	
Patient Employment	$	Rent or Mortgage	$
Spouse Employment	$	Food	$
Social Security	$	Telephone(s)	$
SSI	$	Cellphone(s)	$
SSD	$	Electricity/Water/Gas	$
Veterans Benefits	$	Cable/Internet	$
Food Stamps	$	Auto(s) Payment	$
Child Support	$	Auto(s) Gas/Tax Fees	$
Other	$	Medical Insurance	$
		Patient Medications	$
		Family Medications	$
		Life Insurance	$
		Home Insurance	$
		Auto(s) Insurance	$
		Other Insurance	$
		Credit Card	$
Total Income:		**Total Expenses:**	

2980 SE 3rd Court, Ocala, FL 34471
Tel 352-671-5013 | Fax 866-671-7131
ocalamarioncountykidneyfoundation.org

- Please provide a complete explanation of why you would benefit from this award by answering the follow questions:
  - Why should the Marion County Kidney Foundation give this award to you?
  - What plans and goals do you have post-transplant to resume a healthy and active life?
  - How will you raise future funds if needed for post-transplant? (This is especially important if the American Kidney Fund is presently paying your insurance premium, as they will stop paying once you are transplanted)
  - How can you help pay it forward to help other CKD and ESRD Patients?

2980 SE 3rd Court, Ocala, FL 34471
Tel 352-671-5013 | Fax 866-671-7131
ocalamarioncountykidneyfoundation.org

Applicant Signature: _____ Date:_____

In submitting this application, the applicant guarantees its accuracy and truth with the intent that it be relied upon by the Marion County Kidney Foundation in considering assistance to the undersigned. The applicant also agrees that the information in this application may be verified, or that additional supporting documentation may be requested.

2980 SE 3rd Court, Ocala, FL 34471
Tel 352-671-5013 | Fax 866-671-7131
ocalamarioncountykidneyfoundation.org