FINANCIAL INFORMATION

ASSETS		LIABILITIES	
Bank: Checking Account	$	Loans	$
Bank: Savings Account	$	Other Debts	$
Home - Assessed Value	$		
Auto: (Make & Year)	$		
Other			

MONTHLY HOUSEHOLD INCOME		MONTHLY HOUSEHOLD EXPENSES	
Employer:		Rent / Mortgage / Taxes:	$
Spouse's Employer:		Food:	$
Take-Home Pay:	$	Telephone/Cell phone :	$
Spouse's Take-Home Pay:	$	Electricity / Water / Gas:	$
SSI / SSDI:	$	Cable/TV:	$
AFDC:	$	Internet:	$
Retirement Income:	$	Health Insurance:	$
Veteran's Benefit:	$	Auto Payments / Gasoline:	$
Food Stamps:	$	Auto Insurance:	$
Child Support:	$	Patient Medications:	$
Other:		Other Insurance:	$
		Loans:	$
		Credit Cards:	$
		Transport (treatment related):	$
		Other:	$
TOTAL MONTHLY INCOME:	**$**	**TOTAL MONTHLY EXPENSES:**	**$**

ADDITIONAL ORGANIZATIONS WITH WHOM THE APPLICANT HAS APPLIED FOR ASSISTANCE

ORGANIZATION	RESULT
Personal Family Resources	
Brother's Keeper	
Interfaith	
Salvation Army	
Community Action Agency	
Other (please specify)	

APPLICANT / PATIENT AGREEMENT

Applicants Signature: Date:

By 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 application may be verified or that additional supporting documentation may be requested.

MCKF USE ONLY

Date Received:	Approved:	Denied:
Reference #:	|Amount: $	
Advisory Board Members Signature:	Date:	

Please have your Social Worker FAX the completed form to: 866-671-7131

FINANCIAL ASSISTANCE APPLICATION

PATIENT / APPLICANT INFORMATION

Name: _____ Date of Birth: _____

SSN (last 4): _____ Phone: _____ Alt Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Number of Dependents: _____

Spouse's Name: _____

SCREENING INFORMATION

Have you received assistance from MCKF in the past year? ☐ Yes ☐ No

If *yes, please provide the date and the amount of assistance provided:* _____

_____

TYPE OF ASSISTANCE REQUESTED

☐ Food ☐ Dietary Supplements ☐ Rent / Mortgage ☐ ☐ Transportation

☐ Utillities ☐ Medical Equipment ☐ Eyeglasses

☐ Eyeglasses ☐ Medical Services

☐ Family Emergency

Amount Requested: $ _____

Check Payable To: _____

Vendor Name (*if applicable*): _____

SOCIAL WORKER'S INFORMATION

Social Worker's Name: _____ Email: _____

Initials: _____

I attest that the *information on this form is complete & accurate to the best of my knowledge.*

_____

SOCIAL WORKER'S NARRATIVE

Provide a complete explanation of the circumstances which require this financial assistance.
Attach additional pages if needed.

_____

_____

_____

_____