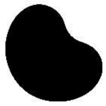

NATIONAL KIDNEY FOUNDATION®
of Michigan

Bob Meyer Patient Emergency Fund Application

PATIENT TO COMPLETE THIS SECTION

Name: ____________________________________

Address: ____________________________________ County: ____________________________________

City: ____________________________________ Email: ____________________________________

Zip: ___________ Date of Birth: ______________ Phone Number: ____________________________

MONTHLY HOUSEHOLD INCOME:

Yours: $ ________ Source ____________________

Other: $ ________ Source ____________________

Total: $ ________ (All others in household)

HOUSEHOLD ASSETS:

Checking Account: $__________

Savings Account: $__________

#people dependent on household income: _____

MONTHLY EXPENSES:

Housing (rent, mortgage, property taxes) $__________

Utilities (gas, electric, phone, water, etc.) $__________

Insurance (health, life, auto, home) $__________

Food $__________

Transportation (gasoline, taxi fare, bus) $__________

Loans (auto, credit card payments, etc.) $__________

Medication expenses $__________

Other monthly expenses (specify) $__________

Total: $ __________

SUPPORT WILL BE PROVIDED THROUGH NKFM CREDIT CARD PAYMENT OF $100 TO A VENDOR, (1)$100 eGIFT CARD, OR (1) $100 GIFT CARD WHICH WILL BE SENT DIRECTLY TO SOCIAL WORKER.

Vendor/Biller Name: ____________________________________

Vendor/Biller Phone: Number: (______)__________________________

Name on Patient's Account:____________________________________

Account Number: ______________________________ **Total Amount of Bill:**________________

OR

Select eGift Card *(Delivery by email)*: ❒ CVS Pharmacy ❒ Target ❒ Walmart

OR

Select Gift Card *(Delivery by US Mail)*: ❒ Meijer ❒ Kroger ❒ Walmart

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:** ____________________

Return completed application to the: National Kidney Foundation of Michigan | Fax: 1-833-292-6778.

Questions? Email: patientservices@nkfm.org

www.nkfm.org/patientservices

Bob Meyer
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 apply)*

❒ Medicare
❒ Blue Cross
❒ Medicaid
❒ Special Health Care Services
❒ HMO/Other
❒ No health insurance

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

____
____
____
____
____

Social Worker Name: ____

Social Worker Email: ____

Phone Number: ______________________________

Fax Number: ______________________________

Facility Name: ____

Facility Address: ____

Updated: 1/11/2022