



NATIONAL KIDNEY
FOUNDATION®

of Michigan

Bob Meyer Patient Emergency Fund Application

PATIENT TO COMPLETE THIS SECTION

Name: _____

Address: _____

City: _____

Zip: _____ Date of Birth: _____

County: _____

Email: _____

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 \$200 TO A VENDOR,
(1)\$200 eGIFT CARD, OR (1) \$200 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: 2/1/2023

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

Questions? Email: patientservices@nkfm.org

www.nkfm.org/patientservices