

KNIGHTS OF COLUMBUS NEW HAMPSHIRE STATE COUNCIL

KIDNEY FUND PROGRAM APPLICATION

Please Note: To be considered for the Kidney Fund Program, the Applicant must answer every question on this form. Failure to do so may result in denial of assistance. Questions that do not apply to you: write in **0**, **none**, or **n/a**. False information will be grounds for immediate termination of Program Benefits. Applicant must be a full time NH resident.

For Official Use Only

PHARMACY

Name:

Address:

City:

Phone: () -

Our Privacy Policy: You have a right to know what we do with the information that we collect about you. We need accurate, current health and financial data so that we can determine your need for assistance. We may discuss your information with the case worker, pharmacy, and doctor that are indicated on this application. Your information will be shared within our organization only by those with the responsibility of determining the need and level of assistance available. We will protect all information provided on this document by physical, electronic, and procedural safeguards. Above all we value your trust and confidence in our ability to manage and protect your important personal information. If you have any questions concerning this policy you may contact the **State Secretary, New Hampshire Knights of Columbus.**

Part 1

APPLICANT:

Last Name:	First Name:	Middle Initial:	Phone: () -
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth: (Month/Day/Year) / /		SSN: - -
Address:	City/Town:	State:	Zip:
How long have you lived at this address?:	Years	Months	
If less than 3 years, list previous address(es):	1)		
	2)		
Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed			Spouse Name:

LIST ALL PERSONS RESIDING WITH YOU:

Last Name:	First Name:	Middle Initial	Relation to Applicant
1.			
2.			
3.			
4.			
5.			

Income:

List income received by yourself, spouse, and all individuals residing with you who contribute toward your support. In addition, be sure to include all other income provided to you by individuals who do not reside in you home.

a) Have you applied to Social Security, Veterans, other benefits or pensions?: <input type="checkbox"/> Yes <input type="checkbox"/> No	
If Yes, identify the source of income:	
Presently receiving that income?: <input type="checkbox"/> Yes <input type="checkbox"/> No	(Project Start Date: Month: Year:)

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b) Type of Income:	Total	Amount to your support
Monthly gross wages:	\$.00	\$.00
Monthly supplemental Social Security benefits:	\$.00	\$.00
Monthly income from individuals residing in your home:	\$.00	\$.00
Monthly income from individuals not residing in your home:	\$.00	\$.00
Monthly income received as contributions:	\$.00	\$.00
Monthly income earned by caring for foster children:	\$.00	\$.00
Monthly income from annuities / trusts:	\$.00	\$.00
Monthly income from unemployment compensation:	\$.00	\$.00
Monthly income from railroad pensions:	\$.00	\$.00
Monthly income from veterans' benefits:	\$.00	\$.00
Monthly income from county welfare:	\$.00	\$.00
Monthly income from state welfare:	\$.00	\$.00
Monthly income from city / town:	\$.00	\$.00
Monthly income from insurance benefits:	\$.00	\$.00
Monthly income from workmen's compensation:	\$.00	\$.00
Monthly income from pension benefits:	\$.00	\$.00
Monthly income from all other source(s), list each:		
1.	\$.00	\$.00
2.	\$.00	\$.00
3.	\$.00	\$.00

c) Are you receiving payment for an accident claim other than workmen's compensation?: Yes No

If yes, List amount: \$.00 **This amount is:** One total payment Monthly Weekly Annually

Name of company making payment on accident claim:

Date of Accident: (Month/Day/Year) / /

d) Do you own your own home?: Yes No If yes, approximate market value: \$.00

e) Do you own any other property?: Yes No If yes, Describe below

Type of Property: (building type, # of acres, etc.)	Approximate market value:
1)	\$.00
2)	\$.00
3)	\$.00

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RESOURCES: Complete the following, listing all resources that you or your spouse and anyone for who assistance is being requested here. Under **“VALUE”** indicate the monetary worth of each item.

TYPE	VALUE	IN NAME(S) OF
Bank Savings:	\$.00	
Bank checking:	\$.00	
Cash on Hand:	\$.00	
Stocks / Bonds:	\$.00	
Life insurance (face value):	\$.00	
Life Insurance (cash value):	\$.00	
Other (describe):	\$.00	
Other (describe):	\$.00	

MEDICAL INSURANCE: Are you covered by the following plans?

a) Medicare: Hospital – Part A : Yes No Date coverage took effect:: (Month/Day/Year) / /
 Medical – Part B : Yes No Date coverage took effect:: (Month/Day/Year) / /
 Prescription Drug – Part D : Yes No Date coverage took effect:: (Month/Day/Year) / /

If you have not applied, explain why: _____

b) Private Medical Insurance : Yes No Certificate number: _____
 Name of Company _____

c) Champus (Veteran’s Medical benefits) Yes No ID Card number: _____
 Retired: Yes No Active duty: Yes No

d) Secondary or Spouse medical insurance: Policy Number: _____
 Yes No

Name of Company: _____

Type of Insurance (describe): _____

WELFARE ASSISTANCE: Have you or your spouse or anyone in your household applied for the following:

1) State Welfare Assistance: Yes No 2) City/Town Welfare Assistance: Yes No

3) County Welfare Assistance: Yes No 4) MediAid (Welfare medical): Yes No

If benefits are currently being received by you or your spouse or anyone in your household for any of the above, indicate by number and list amount. 1) \$.00 2) \$.00 3) \$.00 4) \$.00

Name of person(s) receiving the benefit(s): _____

If you or your spouse or anyone in your household have been denied any of the above benefits, list the name of the person and indicate the reason for denial:

Name: _____ Reason _____

Name: _____ Reason _____

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ADDITIONAL INFORMATION: List the names and address for the following:

Spouse: _____ Address: _____

List all dependents:

NAME	ADDRESS	Relationship to You

Explain the type of help you are requesting from the Knights of Columbus Kidney Fund (be specific): _____

Indicate the amount of financial assistance needed: \$ _____ .00 per quarter

List specific item(s) for which payment or assistance is being requested: _____

How long do you expect to need assistance (explain)? _____

Were you required to file federal income tax return forms last year?: Yes No
If yes, attach copies of all form(s) to this application

I certify that the above information is a true and complete statement of facts to the best of my knowledge and belief, under the penalty of unsworn falsification.

Applicant signature: _____ Date _____

If applicable, the person who helped the applicant prepare this form must sign here.

Preparer signature: _____ Date _____

(Review Committee notations and comments.)

**KNIGHTS OF COLUMBUS
NEW HAMPSHIRE STATE COUNCIL
KIDNEY FUND PROGRAM APPLICATION – Part II
PHYSICIAN CERTIFICATE**

Name of physician completing this form: _____ Date _____

Office address: _____ Phone: _____

Patient Name:	Pharmacy name:
Address:	Address:
City/Town: _____ State: _____	City/Town: _____ State: _____
Zipcode: _____ Phone: _____	Zipcode: _____ Phone: _____

NOTE: ANY UNANSWERED QUESTION WILL RESULT IN DISQUALIFICATION OF THIS APPLICATION

How long have you been treating the patient for kidney disease?: _____

Describe patient's condition: _____

Is patient disabled due to kidney disease? Yes No

If yes, how long will disability last? _____

Describe in general the treatment required for kidney disease: (dialysis, medication only, etc.) _____

How long do you expect treatment to be required? _____

List medication(s) [generic name] to be prescribed specifically for treatment of kidney disease for this patient:

How long do you expect medication to be required? _____

Is patient on dialysis machine?: If yes, location of machine? _____

Physician signature: _____

Name of social services representative: _____ Phone: _____

Email: _____

In your opinion, has the patient exhausted all efforts of available assistance such as Medicare, Medicaid, Private Medical Insurance, etc.? Yes No

Social representative signature _____ Date: _____

Mail Completed Application to:	Joel Plante, State Secretary NH State Council, Knights of Columbus 13 Dick Dame Lane Farmington, NH 03835	As of 7-1-2009
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