



The Kidney Foundation of Central Pennsylvania

Olde Liberty Square, 4813 Jonestown Road, Suite 101, Harrisburg, PA 17109
Phone: 717-652-8123 - FAX 717-671-9444 - Toll Free - 1-800-762-6202

Applicants must provide a copy of the most recent Federal Income Tax Return (Form 1040) unless a copy of a current Medical Assistance card or PA State Chronic Renal Disease Program card is submitted with this application.

Applicants must provide a brief statement of request to describe the financial need, and include copies of bills, etc. that pertain to this request.

PATIENT ASSISTANCE PROGRAM APPLICATION

Name: _____
Address: _____
County: _____
Phone: _____

Birth Date: _____
Social Security # _____
Marital Status: _____
Dependents: _____
Initial Dialysis: _____

Name of Employer: _____
Address of Employer: _____
Health Insurance Carrier: _____

ASSETS

Auto: _____
Home: _____
Checking Account: _____
Savings Account: _____
Stocks/Bonds: _____
Other: _____

MONTHLY HOUSEHOLD INCOME

Salary and Wages: _____
Social Security: _____
Pension: _____
Public Welfare: _____
Veterans Benefit: _____
Child Support: _____
Other: _____
Total: _____

MONTHLY EXPENSES

Rent: _____
Mortgage: _____
Auto Loan: _____
Telephone: _____
Gas/Oil: _____
Electric: _____
Health Insurance: _____
Auto Insurance: _____
Medicines: _____
Credit Cards: _____
Loans: _____
Debts: _____
Other: _____
Total: _____

Name of
Dialysis Unit: _____

Address: _____

Phone: _____

E-mail address: _____

SOCIAL WORKER: _____
(Signature) Print Name

PATIENT SIGNATURE _____ DATE: ____/____/____

By my signature I certify that the information provided above is accurate to the best of my knowledge. I am requesting a review of this information to be considered for financial aid. I understand that this is not a state or federally underwritten program, and that the receipt of assistance from the Kidney Foundation of Central Pennsylvania is dependent upon the availability of funds.