



## **Authorization for Release and Review of Financial Information**

### **To: Kidney Foundation of Northwest Ohio**

The undersigned, individually, and jointly if applicable, hereby grant permission to the Kidney Foundation of Northwest Ohio (hereinafter Foundation) to review my/our financial information which has been submitted with my/our application for financial assistance under the Foundation's renal patient assistance program.

I/We certify that the financial information which is provided herewith has been carefully reviewed by me/us and is true and correct, the undersigned acknowledging that the information is submitted in connection with the application for assistance and with the intention that the Foundation may rely upon such information as submitted in determining the request for patient assistance. I/We agree that in the event any material change shall occur in the report of financial condition provided herewith, I/we shall immediately and without delay notify the Foundation and/or Chapter of such change.

The financial information which has been provided may be released by the Foundation in connection with my/our application for assistance to individuals, both professional and staff, working in the renal healthcare area as the Foundation deem appropriate, reasonable and necessary in evaluating my/our application for assistance.

This authorization and consent to disclose financial information may be revoked by the undersigned at any time by the giving of written notice to that effect, except to the extent that any action shall have been taken in reliance upon the information which has been submitted.

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Client Signature

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Date

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Renal Social Worker Signature

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Date

**Completed applications, including income verification, should be submitted to:**

Kidney Foundation of Northwest Ohio  
3100 W. Central Ave., Ste. 250  
Toledo, OH 43606

(419) 531-6080-fax

(419) 329-2196-phone

[www.kfnwo.org](http://www.kfnwo.org)



**GENERAL ASSISTANCE APPLICATION**

REQUEST FOR: Medication Transportation Mileage Reimbursement Supplement  
Other \_\_\_\_\_

Date \_\_\_\_\_

Patient Name \_\_\_\_\_ Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ County \_\_\_\_\_

Phone \_\_\_\_\_ DOB \_\_\_\_\_ Marital Status \_\_\_\_\_ Gender \_\_\_\_\_

If minor, name of parent or guardian \_\_\_\_\_

Ethnic Origin (for statistical purposes only)

African American  Caucasian  Latin American  Other \_\_\_\_\_  Decline

Treatment Pre-dialysis Hemodialysis Peritoneal Dialysis Transplant Other

Current Employment \_\_\_\_\_ Past Employment/Retired \_\_\_\_\_

**Monthly Household Income**

|         | Wages | Social Security | Pension | VA    | Food Stamps | Other |
|---------|-------|-----------------|---------|-------|-------------|-------|
| Patient | _____ | _____           | _____   | _____ | _____       | _____ |
| Spouse  | _____ | _____           | _____   | _____ | _____       | _____ |
| Child   | _____ | _____           | _____   | _____ | _____       | _____ |
| Other   | _____ | _____           | _____   | _____ | _____       | _____ |

Savings Amount \_\_\_\_\_ Checking Amount \_\_\_\_\_ IRA's, CD's, etc. \_\_\_\_\_

Please include name and date of birth of everyone in the household.

Patient's Total Income \_\_\_\_\_ Total Household Income \_\_\_\_\_

**A COPY OF LAST YEAR'S INCOME TAX RECORD OR A LETTER FROM SOCIAL SECURITY VERIFYING YOUR INCOME IS REQUIRED.**

Insurance  Medicare  Medicaid/Spendedown Amt. \_\_\_\_\_  Other \_\_\_\_\_

Social Worker Name \_\_\_\_\_ Unit \_\_\_\_\_

Physician Name \_\_\_\_\_ Phone \_\_\_\_\_