



Nebraska Kidney Association

We envision a time when the Nebraska Kidney Association provides support and resources to all Nebraskans affected by kidney disease

PATIENT EMERGENCY FINANCIAL AID REQUEST FORM

THIS MUST BE FILLED OUT BY A PATIENT – FORMS SUBMITTED OTHERWISE WILL BE DECLINED

Patient's Name _____ Age _____ Has patient received funds in the last 12 months **Y/N**

Address _____ City _____ State _____ Zip _____

Dialysis Unit _____

Name of Social Worker _____ Social Worker Phone # _____

Email for confirmation _____

Date of Request _____ Amount Requested _____ Date Needed _____

Address _____ City _____ State _____ Zip _____

NEED FOR ASSISTANCE: (Receipts or statements required for any submitted invoices)

Gas for Transportation

_____ Casey's Gas Card

Food emergency assistance

_____ Hy-Vee _____ Super Saver

_____ Baker's _____ Russ's

Utilities (\$200 or less)

_____ electric

_____ LP gas/heating oil/water

Transplant Patients ONLY

_____ Housing

_____ Utilities

_____ Food

_____ Dental (Exam only)

_____ Gas for transportation

Third Party Name (For utilities or Transplant Pts only) _____

Please list other sources of assistance sought and the response to request for assistance:

_____ I am detailing the circumstances regarding this request **(separate sheet)**.

Signature of patient requesting funds _____

Signature of social worker witnessing request _____

All approvals or declines will be emailed to the Social Worker

Program Supported by:



An independent licensee of the Blue Cross and Blue Shield Association